COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Web Portal
Provider
Automated Response System
(ARS)
Users Guide

Version 6.0
Updated: 08/11/2010

HIPPA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. Affiliated Computer Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandate.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by Affiliated Computer Services. It is health care data, plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.[1]

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	06/12/2010	ACS Transition Web Portal Team	Initial Document Creation
1.1	06/19/2010	ACS Transition Web Portal Team	Updated for Member Eligibility Request page changes
2.0	07/11/2010	ACS Transition Web Portal Team	Updated based on DMAS comments
3.0	7/22/2010	ACS Transition Web Portal Team	Updated based on DMAS comments and with revised benefit plan table
4.0	7/30/2010	ACS Transition Web Portal Team	Updated spacing/ formatting
5.0	08/04/2010	ACS Transition Web Portal Team	Added TPL Coverage Code to 271 Service Type Code
6.0	08/11/2010	ACS Transition Web Portal Team	Updated to reflect ARS updates to Claims Status, Service Authorization and Payment History

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0.0 Introduction

The Commonwealth of Virginia's Medicaid Web Portal is a web based system that gives providers and their user organizations access to secured provider services.

The Portal extends the business capabilities of Virginia providers by offering user-friendly tools and resources. You will have access to the secured interactive features of the portal including:

- Claims Status Inquiry

- Member Eligibility and Member Service Limits

- Service Authorization Log and Pharmacy Web PA Request

- Provider Payment History

In the near future new services will be added that will give you the following capabilities:

- Automated Provider Enrollment

- Claim submission through the portal

- Ability to update provider demographic information such as their addresses, phone numbers and email addresses online

In order to take advantage of the Portal and its functions, users must be part of the security structure.

For the sake of this document, a 'user' is defined as any person that will access and use the Web Portal.

If at any time during the registration process you have questions or issues, please contact the Affiliated Computer Services (ACS) Helpdesk toll free at 866-352-0496.

0.1 Security Structure

The security structure of the Web Portal is provider centric versus user centric.

Security access for the Web Portal is based upon a provider organization. A 'provider organization' is defined as either an individual billing or servicing provider or group provider (and the user community in support of them).

The provider organization can be associated with either a NPI (National Provider Identifier) or an API (Atypical Provider Identifier – assigned by the Commonwealth of Virginia for providers that are not eligible for a NPI, such as a transportation provider).

A unique User ID will need to be established for each provider organization a user supports. Any users added to the organization will have the ability to access services based on the role they are assigned.

0.2 User Roles

There is a three-tiered security structure associated with each provider organization. Additional roles will be provided as new services are added.

Primary Account Holder – A Primary Account Holder is the person who will perform the initial web registration. He/she will establish the security needed for the services accessed.

Each provider organization can have only one Primary Account Holder. To change a Primary Account Holder, the Provider will need to notify Affiliated Computer Services (ACS), in writing. Please contact the ACS Help Desk (toll free) at 866-352-0496 for additional information and forms.

The Primary Account Holder can

- Establish Organization Administrators and/or Authorized Users for their organization
- Change roles for any user
- Reset passwords for any user
- Activate and/or deactivate any user
- Unlock any User ID
- Access to all secured provider functionality

Organization Administrator – An Organization Administrator is established by the Primary Account Holder.

An Organization Administrator is not required for a provider organization - some organizations may only have a Primary Account Holder and associated Authorized Users. A provider organization can have one-to-many Organization Administrators, if so desired. Organization Administrators tier up to the Primary Account Holder.

The Organization Administrator has the following capabilities associated with only Authorized Users:

- Can establish Authorized Users for their organization
- Can change roles for any Authorized User
- Can reset passwords for any Authorized User
- Can activate and/or deactivate any Authorized User
- Can unlock any Authorized User ID
- Has access to all secured provider functionality

Authorized User - The Authorized User is responsible for performing provider support functions.

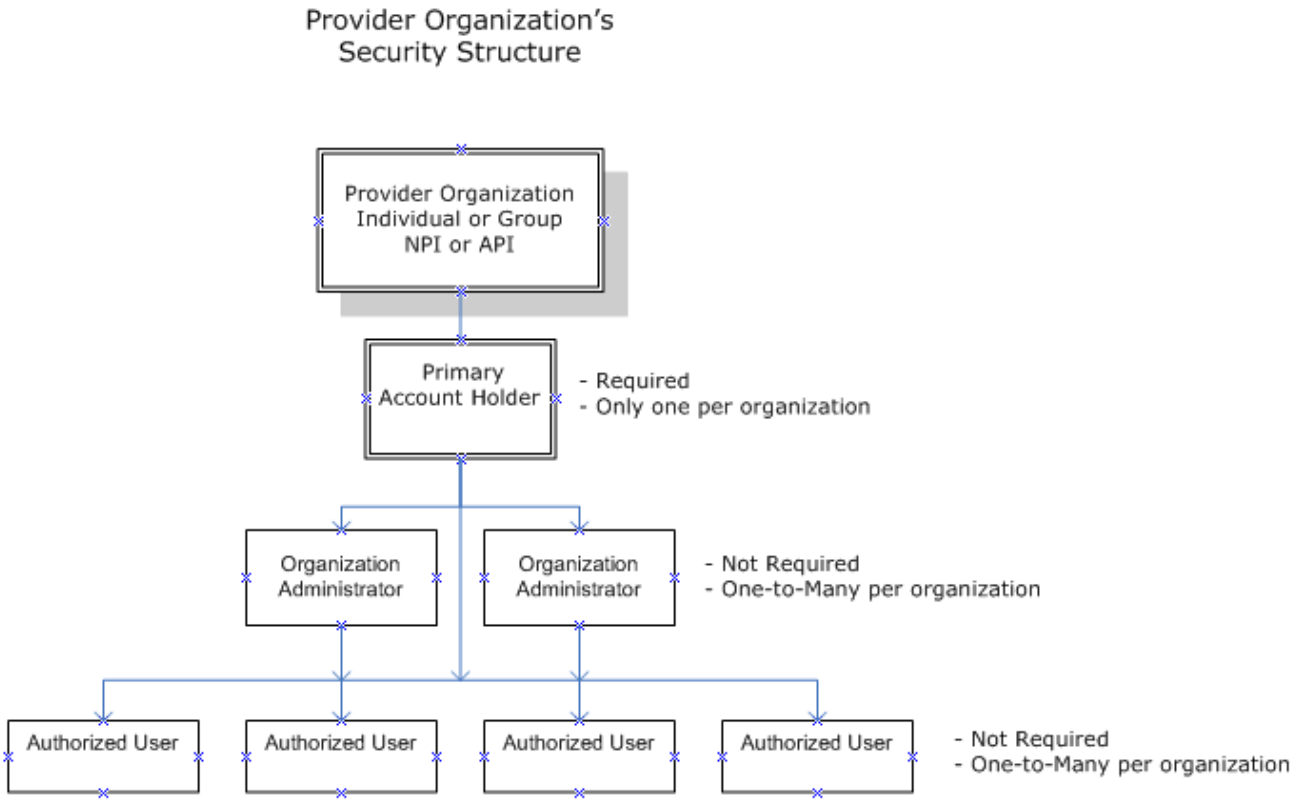
Authorized Users are not required for a provider organization, but an organization can have one-to-many Authorized Users, if so desired. Authorized Users tier up to the Organization Administrators.

The Authorized User has the following capabilities:

- Has access to all secured provider functionality

Within the provider organization's security structure, the users within each tier are accessible within the system to all users in the tiers above. All Authorized Users can be accessed and user maintenance performed for them by all Organization Administrators and the Primary Account Holder.

The following reflects the security structure for each provider organization.



0.3 Overall Registration Process

The Web Registration process for new provider organizations must be completed by the Primary Account Holder.

The registration process involves the following three steps:

1. Establish a User ID, password and security profile
2. Initiate the authentication process
3. Complete identity authentication with the Security ID generated and mailed to the provider

For more details, please see the Provider Registration Users Guide.

1.0 Web Portal Access & Navigation

The new Virginia Medicaid Web Portal can be accessed through the following link: www.virginiamedicaid.dmas.virginia.gov

The Web Portal is available daily 24 x 7 with the exception of routine maintenance which will be posted in advance.

The following sections will outline the basic functionality of the portal.

1.1 Medicaid Web Portal – Home Page

The Commonwealth of Virginia Medicaid Web Portal's home page contains various portlets (sections within a portal page) and navigational tabs.

The Web Portal's Home Page is reflected below:

1.1.1 Navigation Tabs

Provider Services – This tab provides access to the following:

- Provider Enrollment – access to provider enrollment applications for downloading
- Provider Manuals – access to provider manuals, service center user manuals, dental manuals and forms
- Medicaid Memos to Providers – Medicaid Memorandums from DMAS to the provider community
- DMAS Provider Services – link to Provider Services on the Department of Medical Assistance Services web site
- DMAS Pharmacy Services – link to Pharmacy Services on the Department of Medical Assistance Services web site

Provider Resources – This tab provides access to the following:

- Provider Manuals – access to provider manuals, service center user manuals, dental manuals and forms
- Provider Links – links to Center of Medicare and Medicaid Services, DMAS and Virginia.gov websites
- Provider Training – access to the provider training library

- Web Registration – access to Registration FAQ, a Registration Quick Reference Guide, this Registration User's Guide and access to the Registration tutorial
- Automated Response System (ARS) – access to the ARS Users Guide, ARS FAQ and ARS tutorials
- Search for Provider - link to Search for Provider on the Department of Medical Assistance Services web site

EDI Support – This tab provides access to the following:

- EDI Companion Guides – links to the EDI companion guides for support of EDI transactions
- EDI FAQ – Frequently Asked Questions on EDI transactions
- EDI Testing – Guidelines for EDI testing
- EDI Forms and Links – access to EDI forms and links

Documentation – This tab provides access to the following:

- Provider Forms – access to various forms in support of provider services
- Paper Claim Forms – access to various claims forms for download

FAQ – This tab provides access to the following:

- ARS FAQ
- EDI FAQ
- Registration FAQ

1.1.2 Home Page Portlets – Web Announcements

Web Announcements – this portlet contains any information that is applicable to all portal users such as maintenance down time, new policies, etc

1.1.3 Home Page Portlets – Quick Links

Quick Links – this portlet list links to documents or websites that are applicable to the audience viewing this portal page. Quick Links will be located on various portal pages. For consistency and availability to common information, the first five (5) links will always be the same as the navigation tabs:

- Provider Services
- Provider Resources
- EDI Support
- Documentation
- FAQ

In addition there are links that are applicable to that portal page.

For the Home Page, the additional quick links are the following:

- **Web Registration Reference Material** - access to Registration FAQ, a Registration Quick Reference Guide, this Registration User's Guide and access to the Registration tutorial
- **DMAS Web Site** – link to the website for the Department for Medical Assistance Services

1.1.4 Home Page Portlets – Login

This portlet is used for logging in to the pages needed for secured login. The login choice is based upon the user's role. For registration and access to secured provider functionality, select the 'Provider' role.

1.2 Medicaid Web Portal – Provider Login Page

After selecting the 'Provider' role in the Web Portal Home Page, the provider and the supporting user community are directed to the Provider Login Page.

The Provider Login Page is reflected below:

There are three portlets on this page different from the Web Portal Home Page.

- Welcome portlet
- First Time User Registration portlet
- Existing User Login portlet

1.2.1 Welcome Portlet

The Welcome portlet is reflected below:

This portlet contains general instructions as well as mechanisms to handling issues or questions:

- Web Registration Reference Material – from the quick links
- ACS Help Desk – toll free number

1.2.2 First Time User Registration Portlet

The First Time User Registration portlet is reflected below:

This portlet outlines the steps needed for completing the registration process. Only the user designated as the Primary Account Holder should complete the registration process.

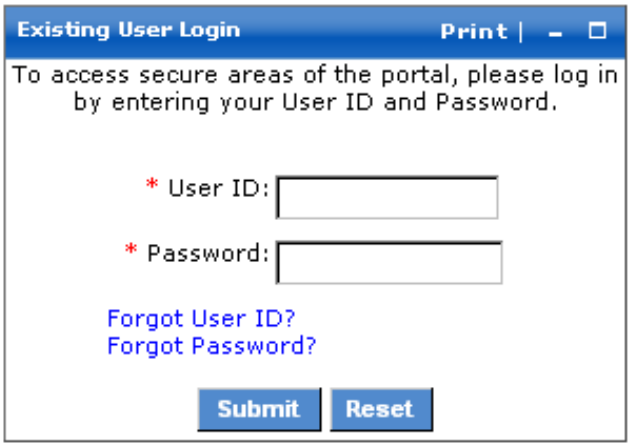
Users that are not designated as the Primary Account Holder should contact their Primary Account Holder or Organization Administrator for their User ID and temporary password.

As the Primary Account Holder, not previously registered (or converted from the UAC), you'd select 'Web Registration' link on this portlet.

1.2.3 Existing User Login Portlet

Once you have established your User and Security Profiles, you will have access to the portal functionality for such things as requesting and applying a Security ID or accessing secured provider services.

The Existing User Login portlet is reflected below:



This portlet is used for applying a registered user's User ID and password. Both are required fields (indicated with a red asterisk *) for the login process.

User ID – this is the User ID created during the registration process when establishing your User Profile (see Registration Users Guide).

Note: If a previous FHSC UAC user, your User ID will be the ID sent in a letter to your Provider (or Administrator for a Group Provider).

Password – this is the Password created during the registration process when establishing your User Profile.

Note: If a previous FHSC UAC user, your password will be the temporary password sent in a letter to your Provider (or Administrator for a Group Provider).

Enter your User ID and Password and click 'Submit'

The Forgot User ID and Forgot Password are addressed in further detail below

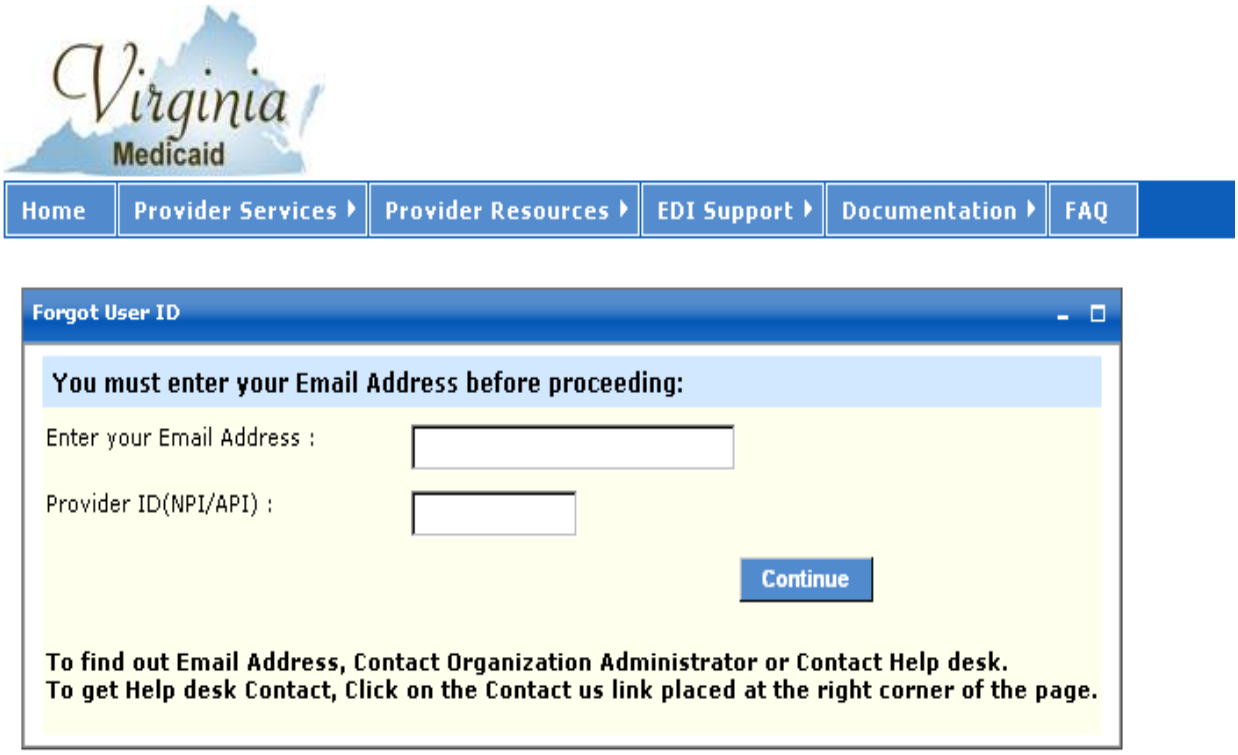
1.3 Forgot User ID

Once you've completed your User and Security Profiles, you are able to leverage the user self help capabilities of the portal. Authorized Users who forget their User ID can get with their Primary Account Holder or any Organization Administrator associated with this provider organization. They have the capability to look up the User IDs. An Organization Administrator can check with the Primary Account Holder.

All roles have the ability to also request their User ID be emailed to them.

On the Provider Login Page, in the Existing Users Login portlet there is an option for Forgot User ID?

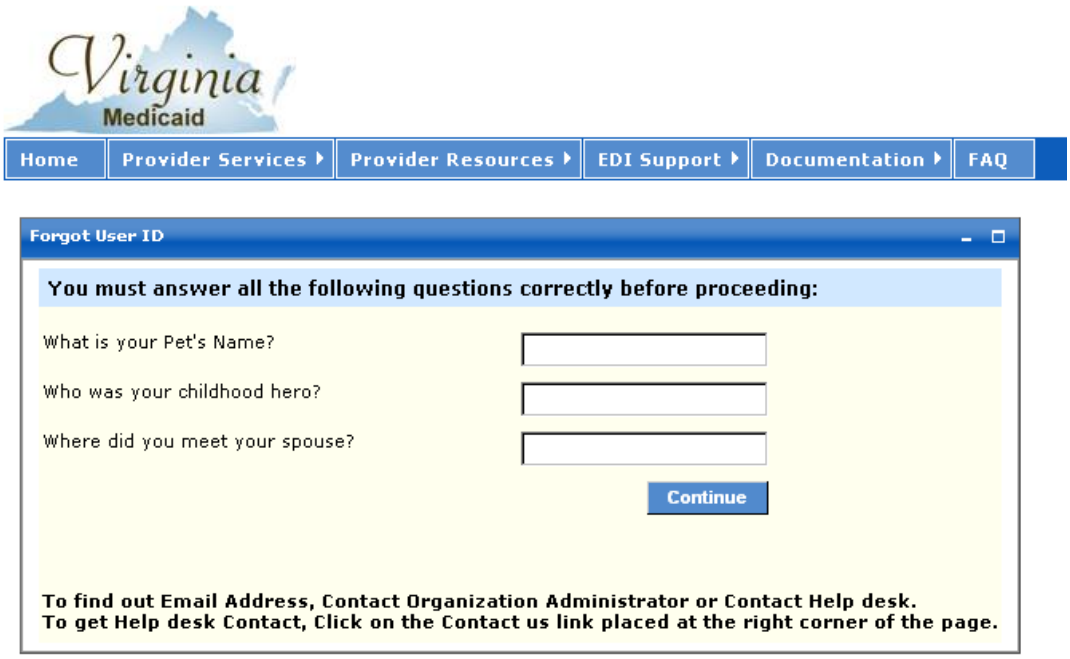
Select 'Forgot User ID?'



Enter your Email Address: - this must be the preferred email that was entered in your User Profile at the time of initial entry (or the last update to your User Profile).

Provider ID (NPI/API): - enter the NPI or API associated with your User ID

Click 'Continue' and you will be routed to the portlet below.



This portlet will display the three questions you chose when establishing your Security Profile.

You must complete all three of these questions, giving the same answers as you established in your Security Profile.

Upon completing the answers, click 'Continue' to invoke the validation of answers to your Security Profile.

After successful validation you will receive the following portlet:

Your User ID will be emailed to the email address entered in your User Profile.

The following is a sample email with the User ID removed:

Your Forgot User ID request has been processed.

Your User ID is :

[redacted]

Please use this to log in to the Virginia Medicaid Web Portal at https://www.virginiamedicaid.dmas.virginia.gov .Please contact the ACS Web Support Call Center, toll free, at 1-866-352-0496 if you have any questions or problems regarding your web portal registration.

Note: This is an auto-generated email, please do not reply.

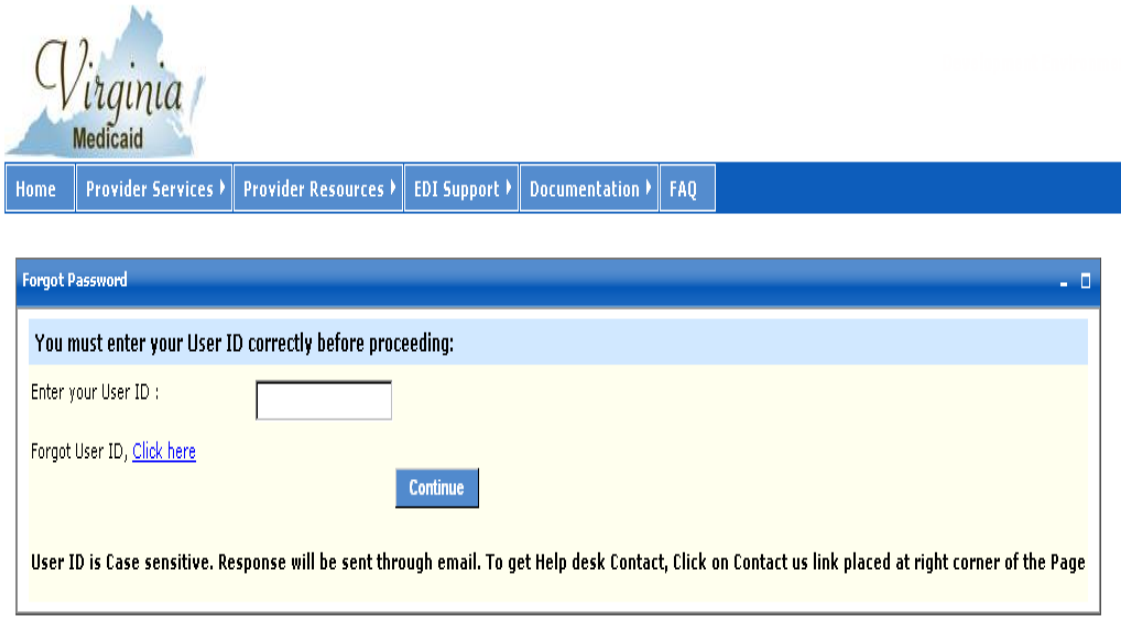
1.4 Forgot Password

Once you've completed your User and Security Profiles, you are able to leverage the user self help capabilities of the portal. Authorized Users who forget their password can get with their Primary Account Holder or any Organization Administrator associated with this provider organization. They have the capability to generate a temporary password. An Organization Administrator can check with the Primary Account Holder.

All roles have the ability to also request their password be emailed to them.

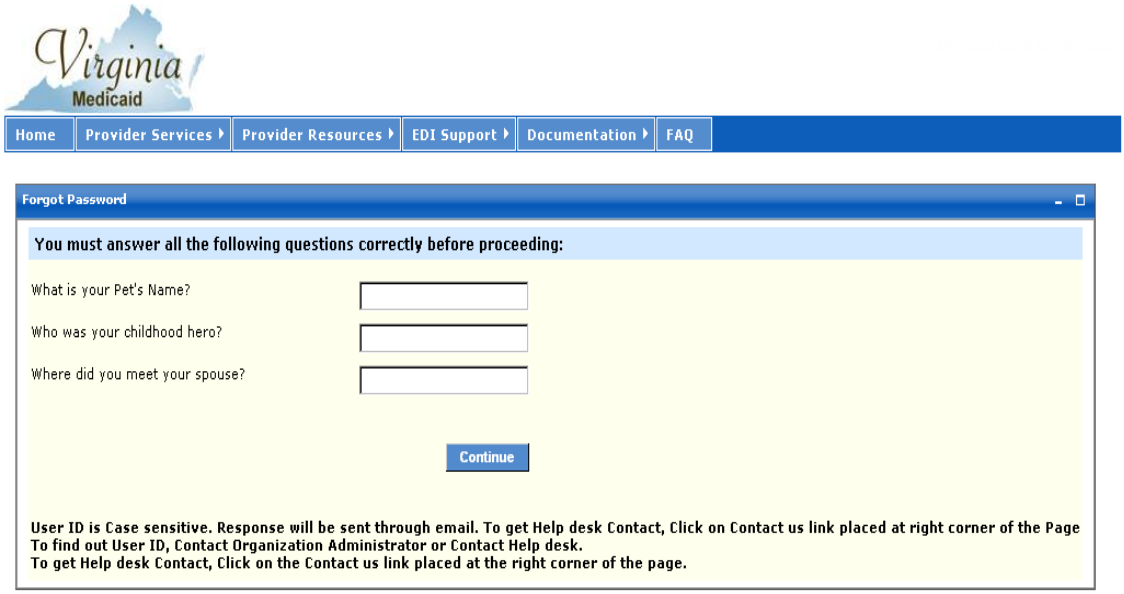
On the Provider Login Page, in the Existing Users Login portlet there is an option for Forgot Password?

Select 'Forgot Password?'



Enter your User ID: - enter your User ID created in your User Profile

Click 'Continue' and you will be routed to the following portlet:



This portlet will display the three questions you chose when establishing your Security Profile.

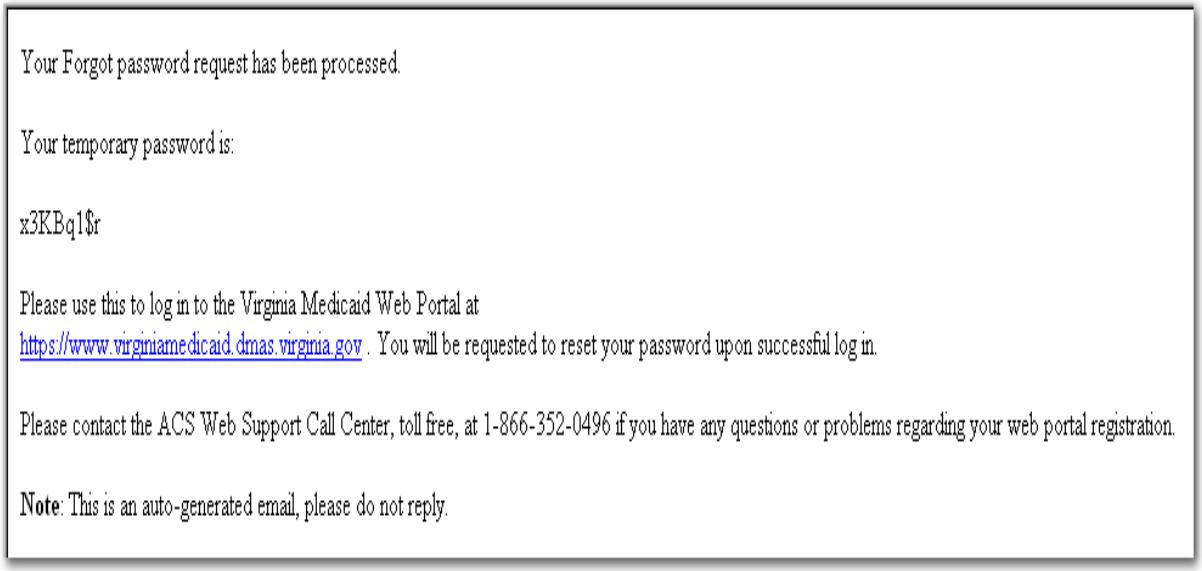
You must complete all three of these questions, giving the same answers as you established in your Security Profile.

Upon completing the answers, click 'Continue' to invoke the validation of answers to your Security Profile.

After successful validation you will receive the following portlet:

A temporary/one-time use password will be emailed to the email address entered in your User Profile.

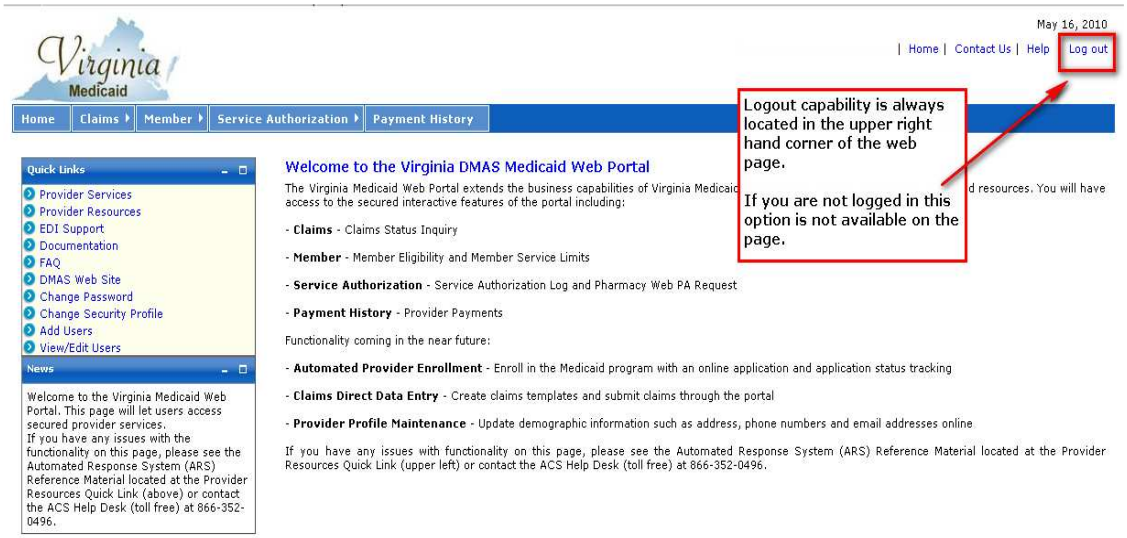
The following is a sample email:



This temporary password will be used for login. You will immediately be taken to your User Profile and will be required to enter another password.

1.5 Log Out

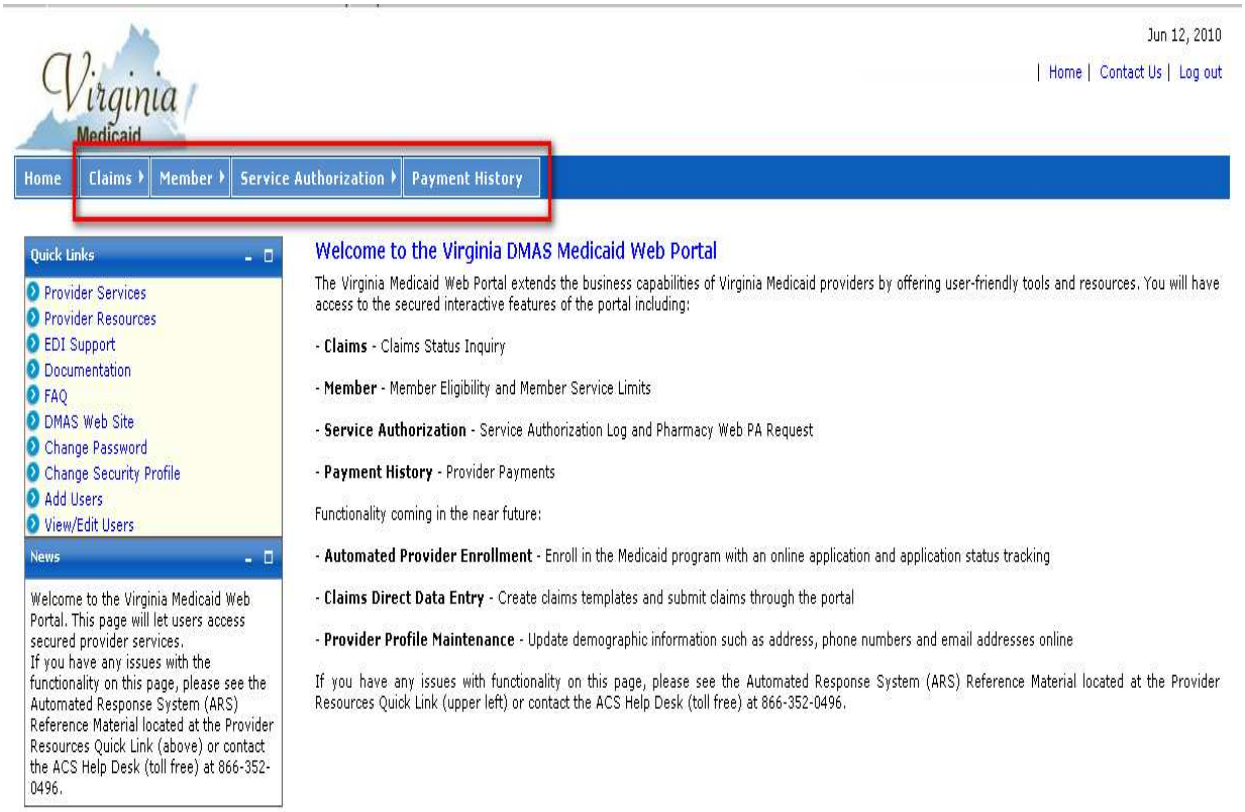
The log out functionality is available on any secured web portal page. The Log Out link is reflected below:



If you are not logged in and are still on public pages, this link is not available as it's not applicable until you've accessed secured portal pages.

2.0 Accessing the ARS

Upon successful login you will be directed to the secured Provider Welcome Page.



The Provider Welcome page consists of the navigation tabs that are the menu to the Automated Response System (ARS) functionality.

2.1 Automated Response System (ARS) Menu

The menu tables will give you access to the following:

Claims – Claims Status Inquiry

Member – Member Eligibility and Service Limits Inquiry

Service Authorization – Service Authorization Log and an access link for a Web PA Request

Payment History – Provider Payments

By hovering over or selecting the desired tab you will be directed to a Request page.

The Request page will require the entry of appropriate criteria that will allow you to limit your search results.

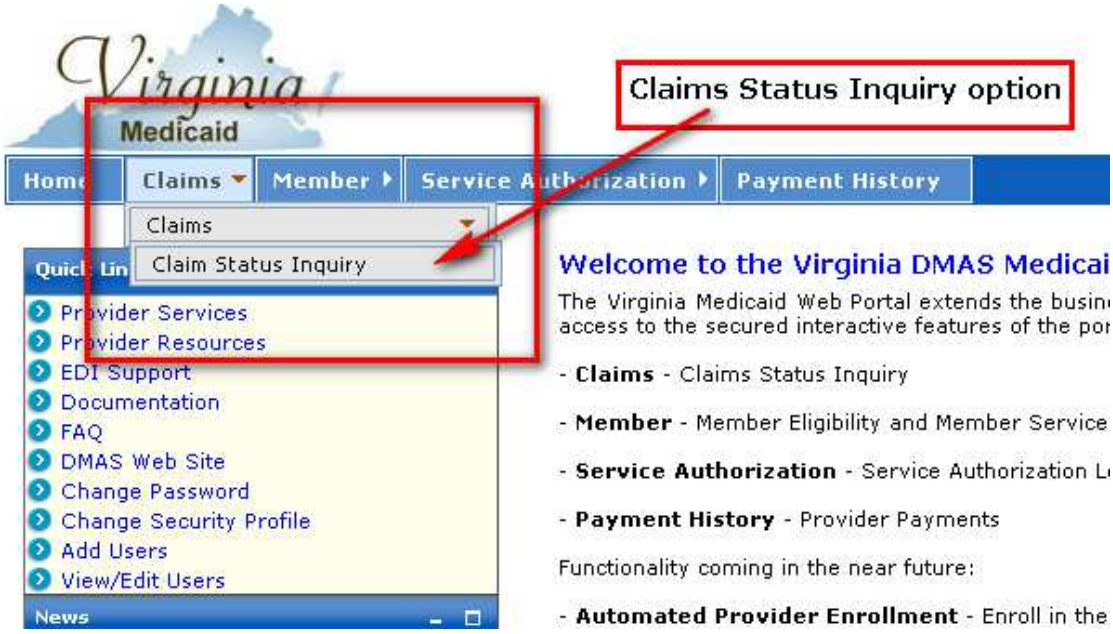
The Search Results page will reflect any records that meet the search criteria. You will select the desired search record for additional detailed information.

The Response page will reflect the requested information.

The following sections will detail the Request, Search Results and Response pages for each of the available ARS functionality.

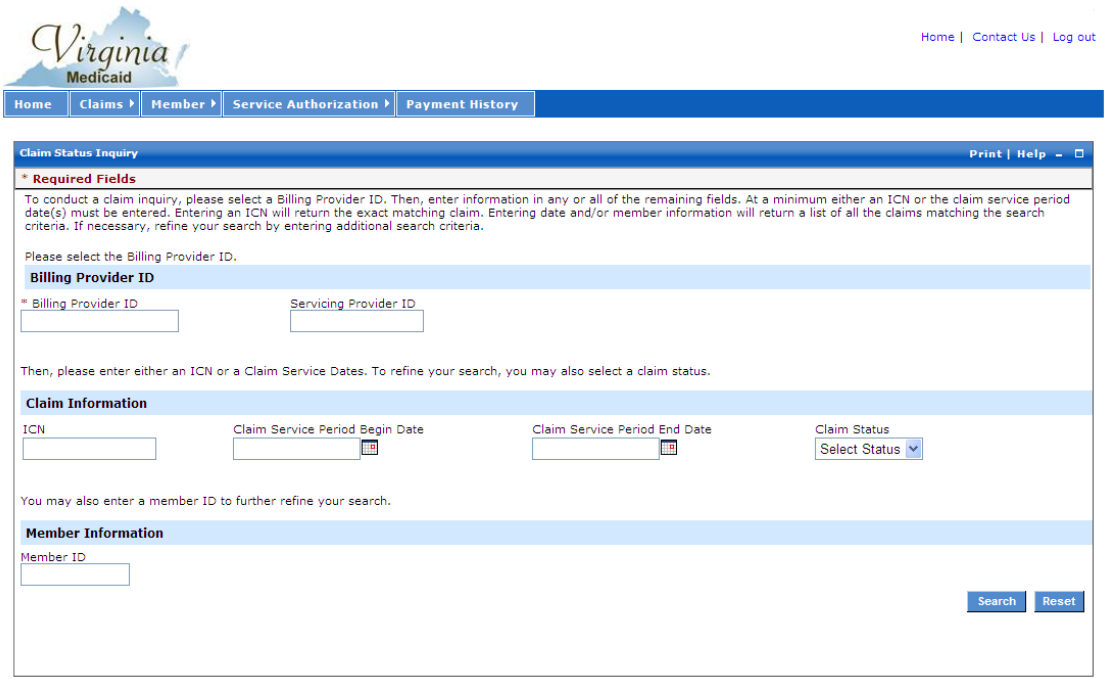
3.0 Claims Status Inquiry

Select the Claims Status Inquiry from the Claims drop down menu.



You will be directed to the Claims Status Inquiry Request portal page for selection criteria entry.

3.1 Claims Status Inquiry – Request Page



The Claims Status Inquiry has both required and optional search criteria.

Required Search Criteria

- Billing Provider ID – This field defaults to the NPI associated with the User ID used at the time of login

Optional Search Criteria – To be used in conjunction with the Billing Provider ID

- Servicing Provider ID – The NPI associated with a provider who performed services for the Billing Provider noted

AND/OR

- ICN – The Internal Control Number associated with a particular claim

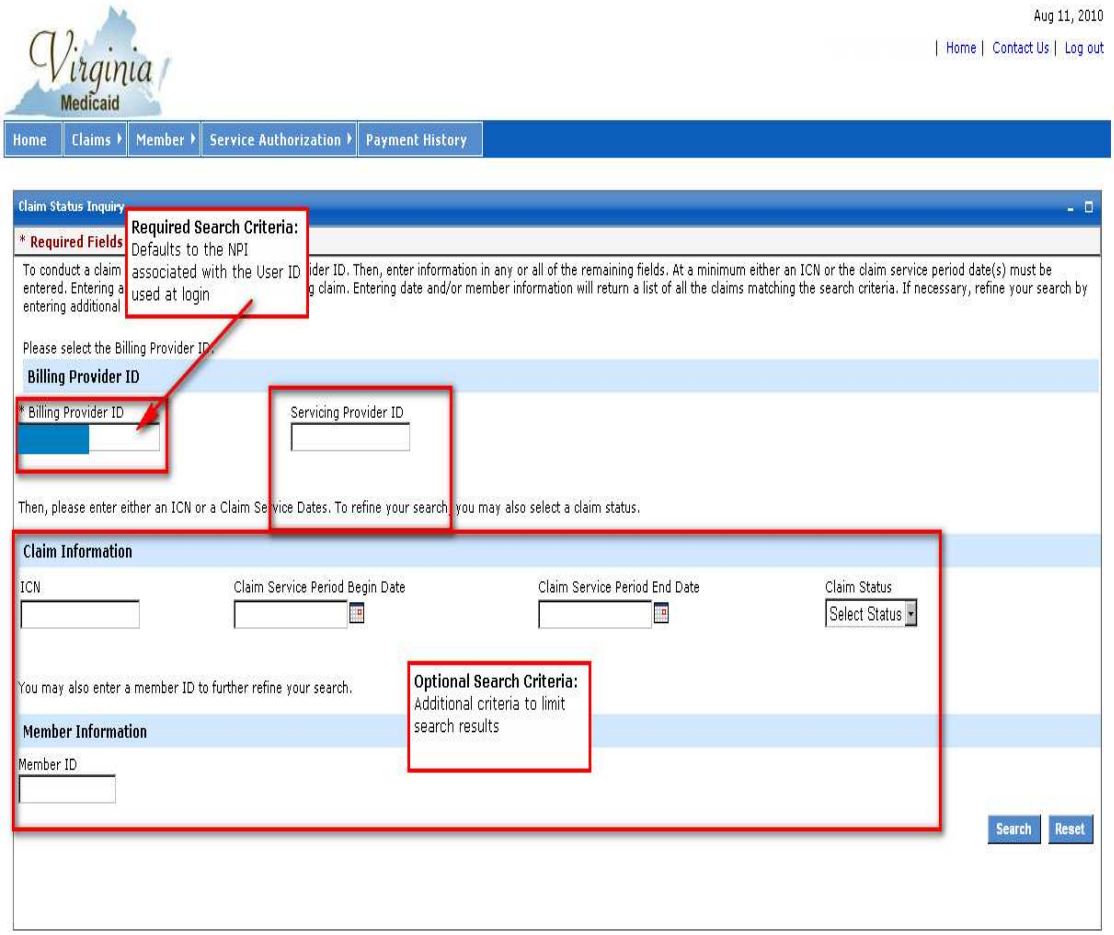
OR

- Claims Service Dates – The service begin and end dates
    - Date format – MM/DD/CCYY
    - If no service dates are entered, the default will be the current date
    - Service date range can not span more than one (1) month
    - If the service date range is just one day, the date will need to be entered in both the begin and end date fields
    - The service date(s) must be within the last 24 months.

- Claims Status – Status of the claims to be returned in the results selection
    - The claims status will be used in conjunction with the service date range (including the current date default)
    - Claims Status drop down options:
        - Paid
        - Denied
        - Pended
        - To Be Paid
        - To Be Denied

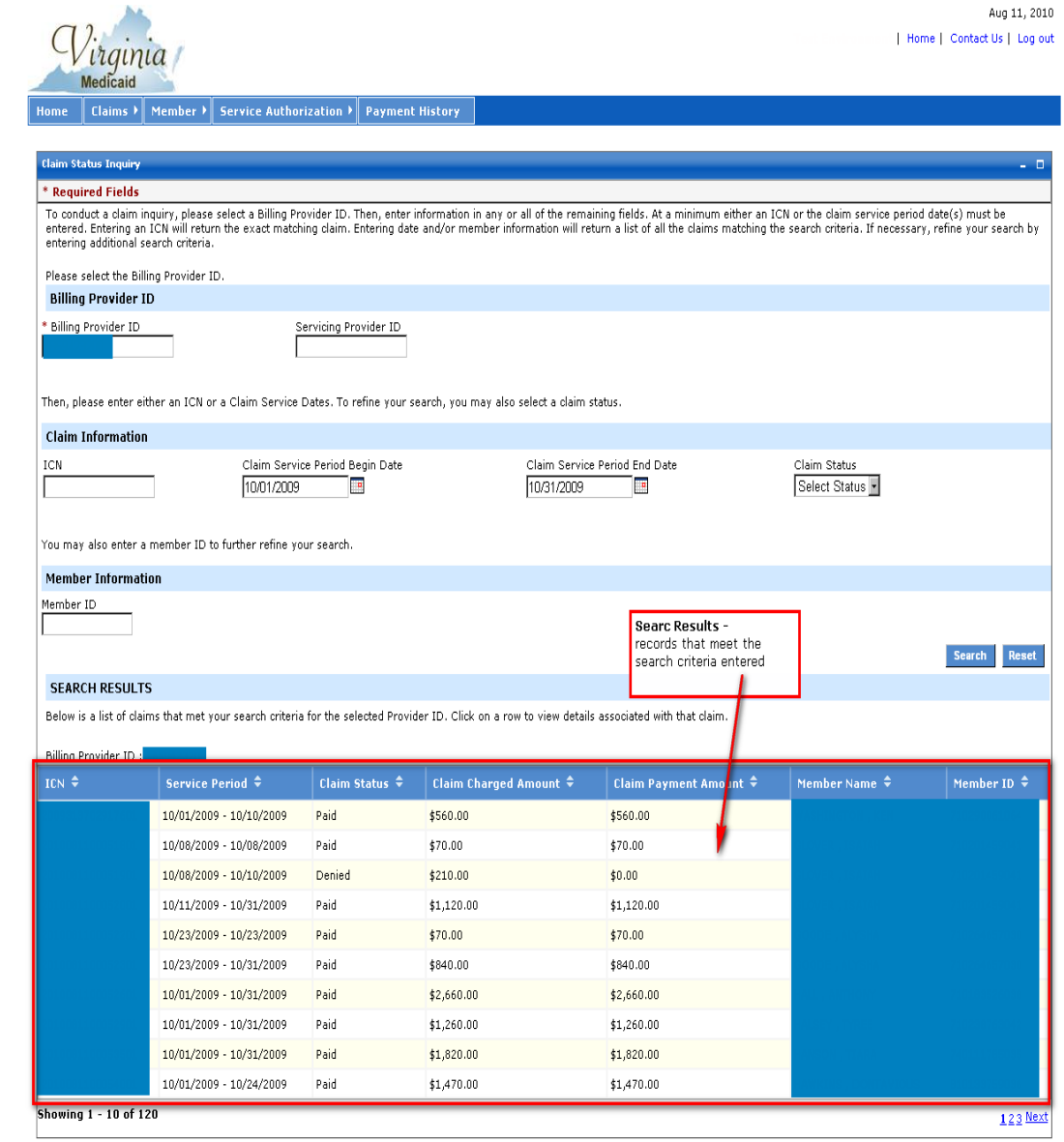
AND/OR

- Member ID – The Medicaid ID number associated with the Member
    - This criteria can be used independently or in conjunction with the service date range and/or the claims status



After entering any desired selection criteria, you will click 'Search' to obtain any records resulting from the search criteria.

3.2 Claims Status Inquiry – Search Results



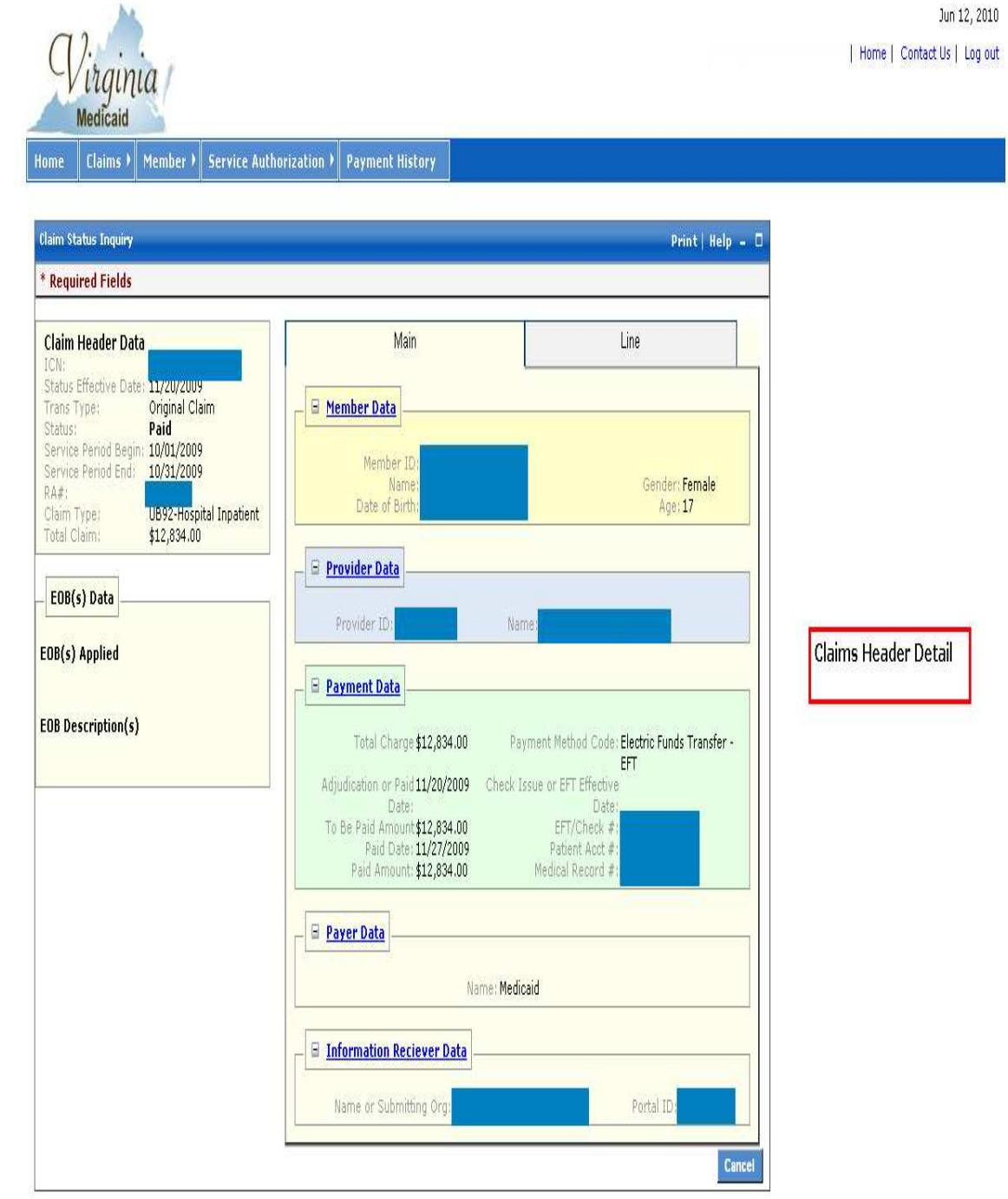
Results that match the search criteria entered will be displayed in the 'Search Results' section.

Clicking on the individual search result record will direct you to the Response page containing detailed information for that record.

3.3 Claims Status Inquiry – Response Page

The Claims Status Inquiry results reflect the claim header and line detail.

3.3.1 Claims Status Inquiry – Header Detail



The Claims Status – Header Detail is divided in to the following sections:

Claim Header Data
- ICN
- Status Effective Date
- Transaction Type
- Claim Status
- Service Period Begin Date
- Service Period End Date
- RA#
- Claim Type
- Total Claim

EOB(s) Data
- EOB(s) Applied
- EOB Description(s)

Member Data
- Member ID
- Name
- Date of Birth
- Gender
- Age

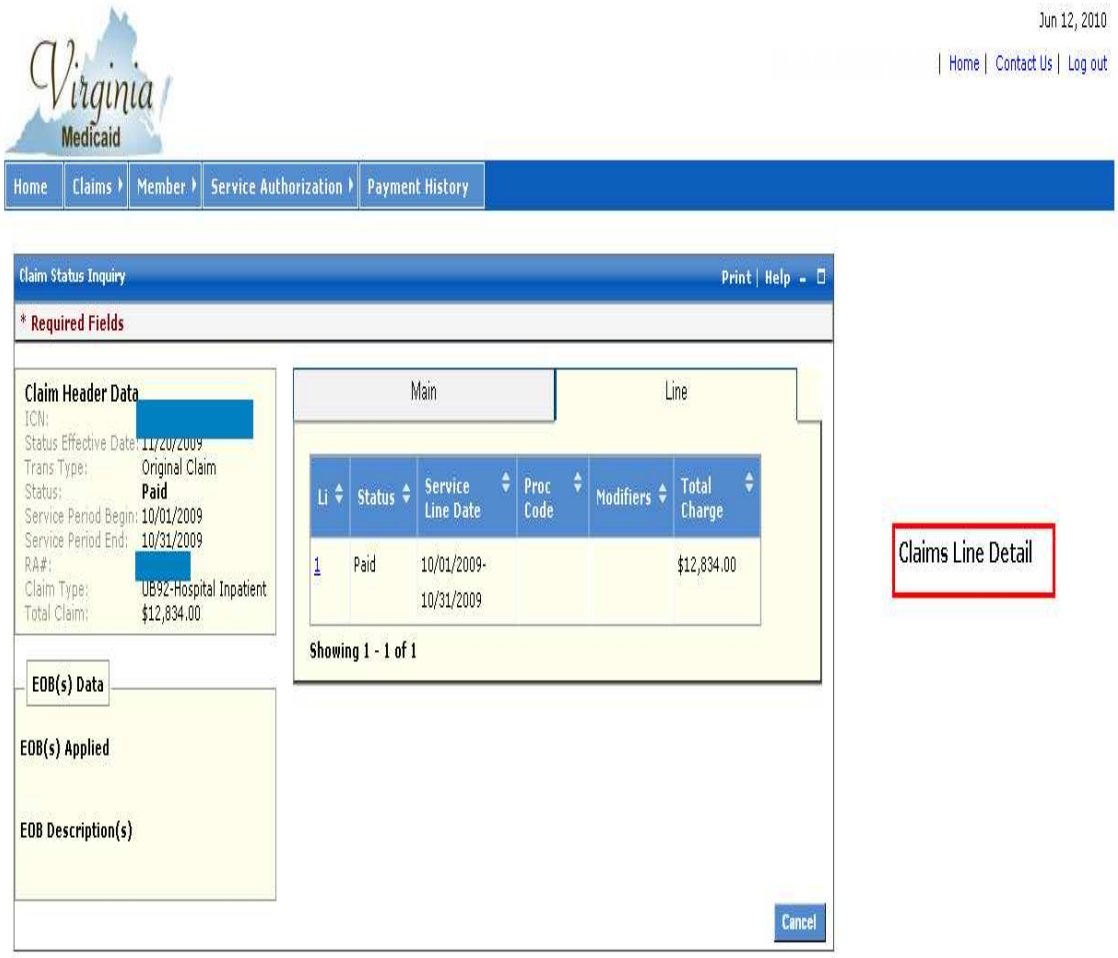
Provider Data
- Provider ID
- Name

Payment Data
- Total Charge Amount
- Adjudication or Paid Date
- To Be Paid Amount
- Paid Date
- Paid Amount
- Payment Method Code
- Check Issue or EFT Effective Date
- EFT/Check #
- Patient Account#
- Medical Record#

Payer Data
- Payer Name

Information Receiver Data
- Name or Submitting Organization

3.3.2 Claims Status Inquiry – Line Detail



The Claims Status - Line Detail contains the following information:

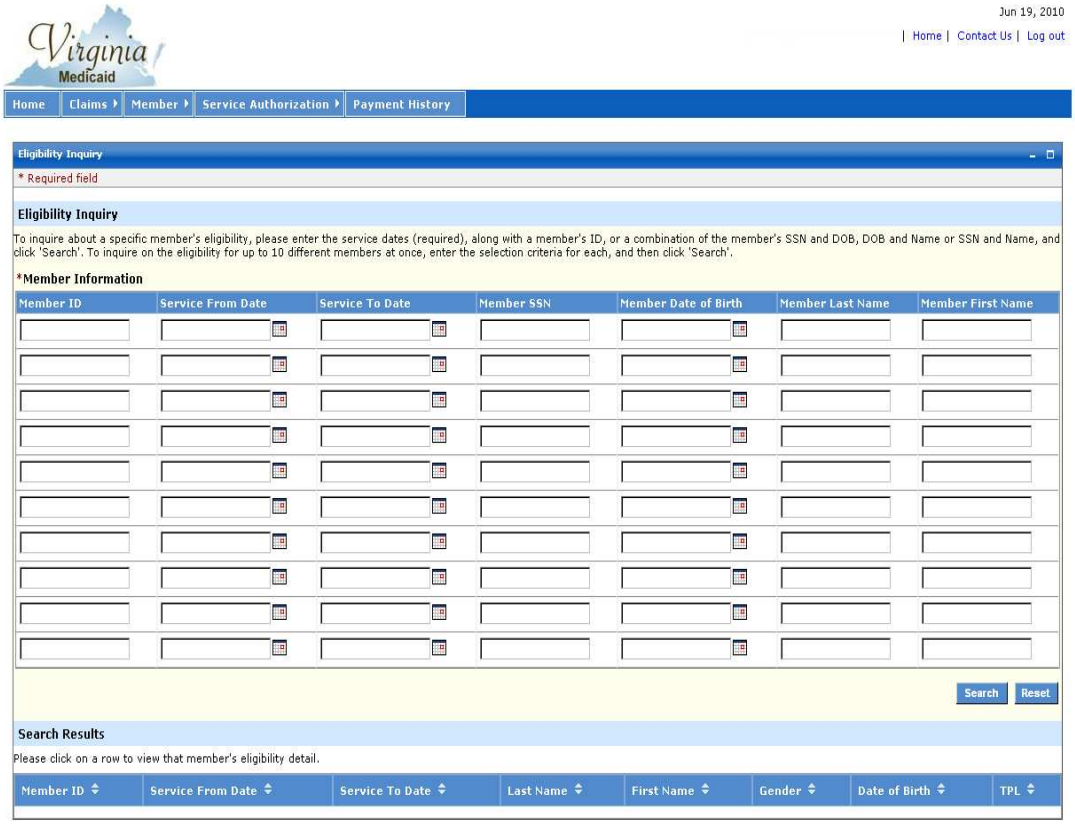
- Line Number
- Line Status
- Service Line Date
- Procedure Code
- Modifier
- Total Line Charge

4.0 Member Eligibility Inquiry

Select the Member Eligibility Inquiry from the Member drop down menu.

You will be directed to the Member Eligibility Inquiry Request portal page for selection criteria entry.

4.1 Member Eligibility Inquiry – Request Page



The Member Eligibility Inquiry has both required and optional search criteria.

Required Search Criteria – To be used in conjunction with the Member ID or Member information

- Service Dates – The begin and end service dates
    - Date format – MM/DD/CCYY
    - Service date range can not span more than one (1) calendar month (i.e. 06/01/2010 – 06/30/2010)
    - If the service date range is just one day, it will need to be entered in both the begin and end date fields
    - Service From Date must be within one year from the current date
    - Future dates are not allowed with the exception of the following:
        - From the 1st – 20th of the month, results can not go past the end of the current month (i.e. if current date is June 12th, results can not go past the end of June)

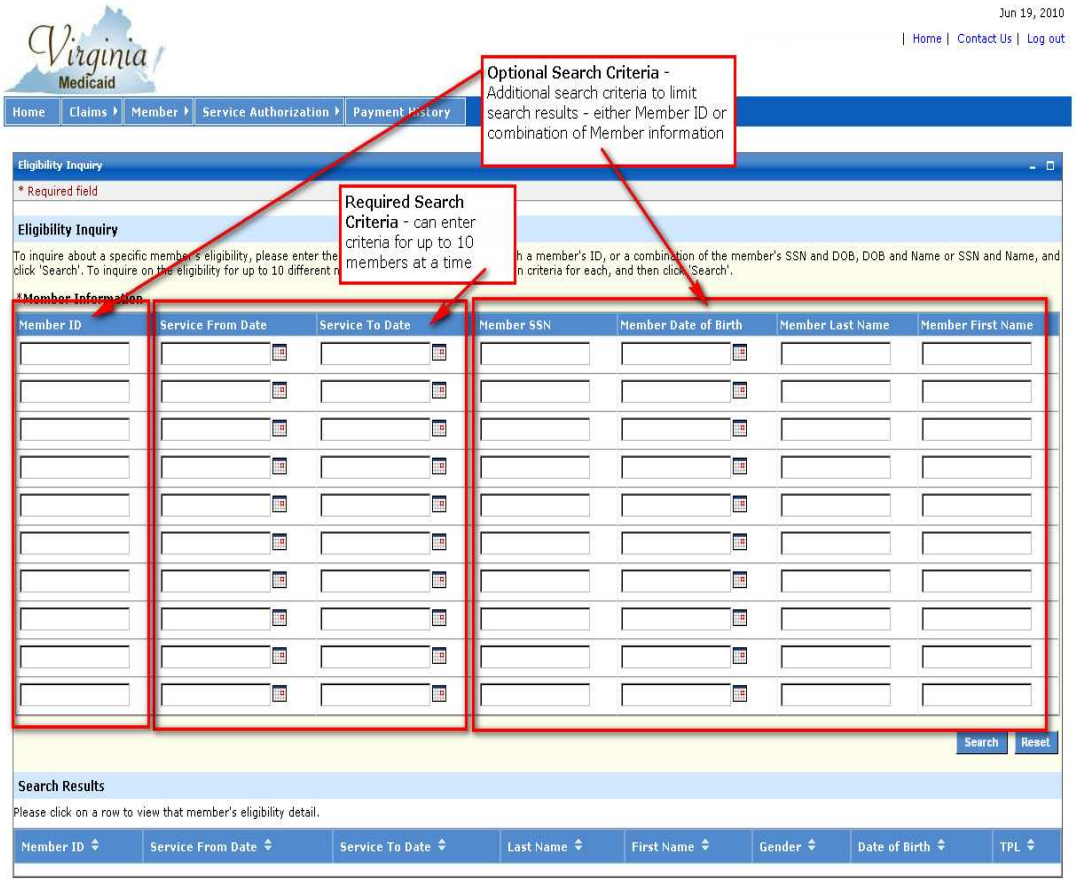
- From the 21st through the end of the month, results can not go past the end of the next month (i.e. if current date is June 24th, results can not go past the end of July)

Optional Search Criteria

- Member ID – The Medicaid ID number associated with the Member

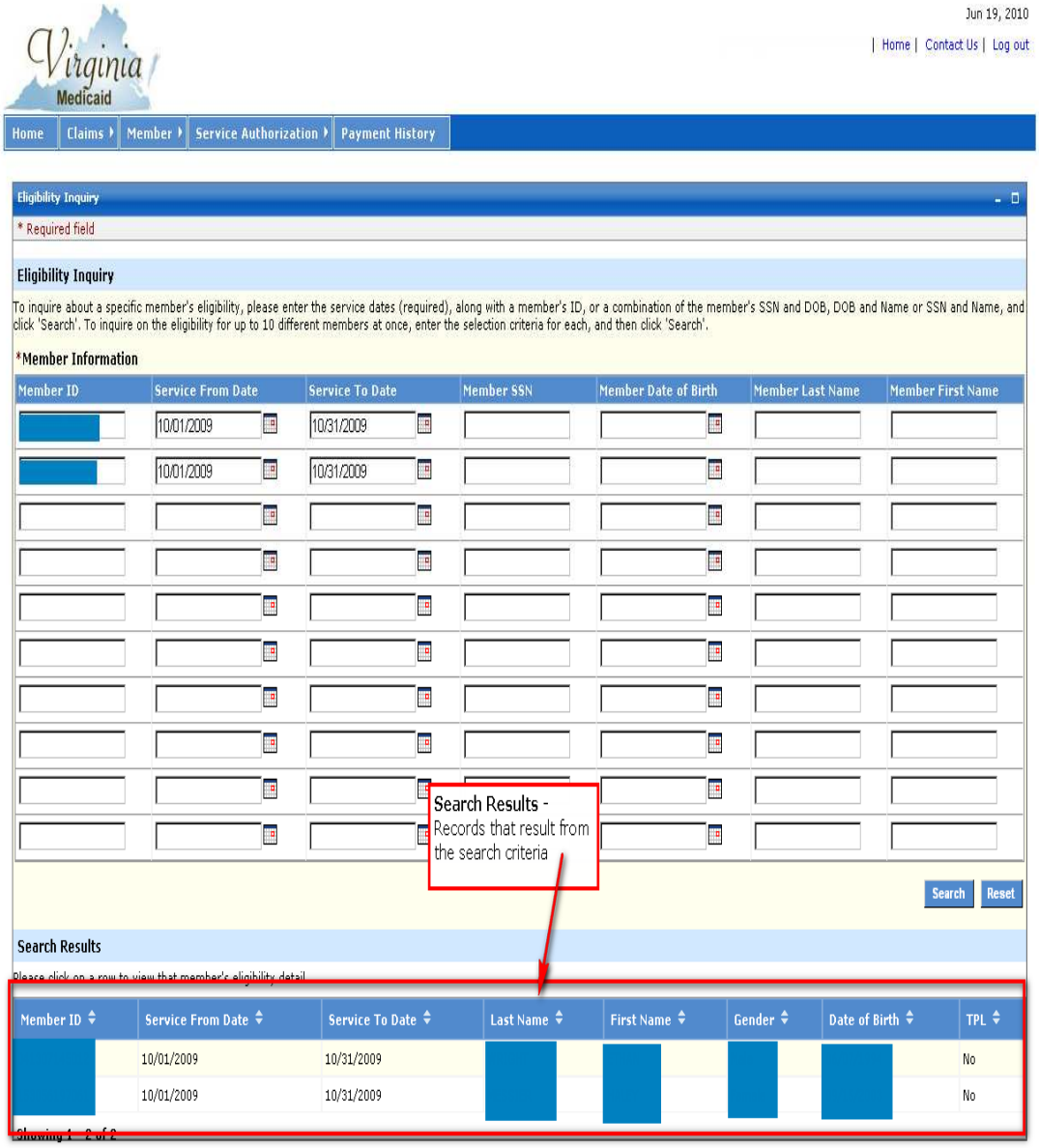
OR one of the following combinations:

- Member SSN and Member Date of Birth
- Member SSN and Member Name (First & Last Name)
- Member Date of Birth and Member Name (First & Last Name)



After entering any desired selection criteria, you will click 'Search' to obtain any search records resulting from the search criteria.

4.2 Member Eligibility Inquiry – Search Results

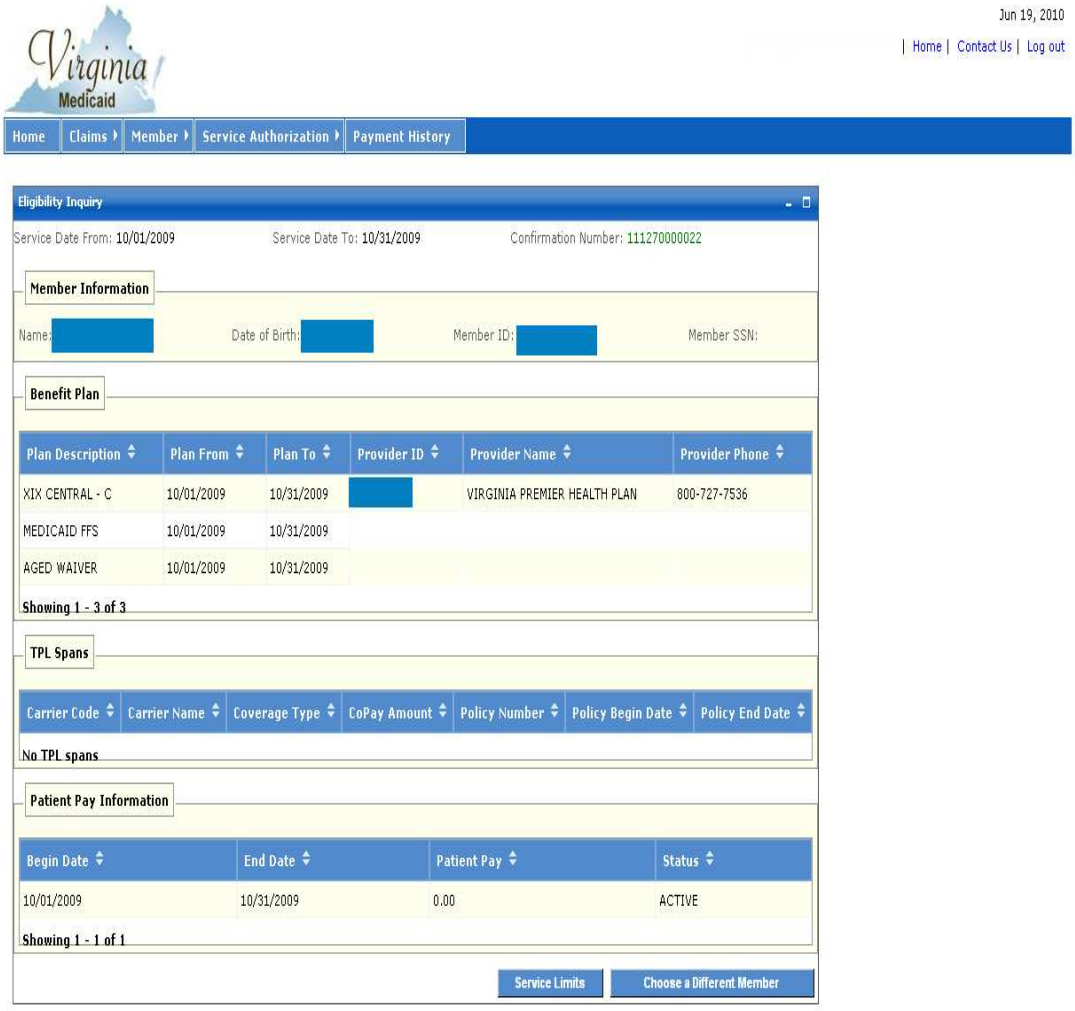


Results that match the search criteria entered will be displayed in the 'Search Results' section.

Clicking on the individual search result record will direct you to the Response page containing detailed information for that record.

4.3 Member Eligibility Inquiry – Response Page

The Member Eligibility Inquiry results reflect member eligibility specific information.



The Member Eligibility detail is divided in to the following sections:

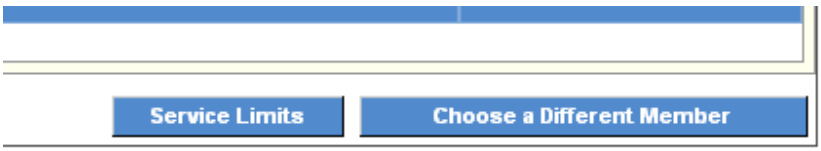
Member Information
- Name
- Date of Birth
- Member ID
- Member SSN (only displayed if entered as part of the search criteria)

Benefit Plan
- Plan Description (see table on page 42)
- Plan From Date
- Plan To Date
- Provider ID
- Provider Name
- Provider Phone

TPL Spans
- Carrier Code
- Carrier Name
- Coverage Type (Service Type Code) (see table on page 45)
- CoPay Amount
- Policy Number
- Policy Begin Date
- Policy End Date

Patient Pay Information
- Begin Date
- End Date
- Patient Pay
- Status

From this portal page, you can select to inquire on the member's service limits by clicking on 'Service Limits' or select another member by clicking on 'Choose a Different Member'.



The Plan Description in the Benefit Plan section contains abbreviated descriptions. The following table cross-references a short description with a full description.

Abbreviated Description	Full Description
Aged Waiver	Elderly and Disabled Waiver
AIDS Waiver	AIDS Waiver
Alzheimer Al	Alzheimer's Assisted Living
ASM ACR ASSM	ACR Assessments
ASM NH LVL 1	Assessments Nursing Home Level 1
ASM NH LVL 2	Assessments Nursing Home Level 2
CMH Waiver	CMH Waiver
DS Waiver	Day Support Waiver
EI	Early Intervention
FAMIS - CDPR	FAMIS - Medallion II CDPR
FAMIS - Halr	FAMIS - Medallion II Halifax
FAMIS - LSWV	FAMIS - Medallion II LSWVA
FAMIS - MCO	FAMIS - Default Mandatory MCO
FAMIS - USWV	FAMIS - Medallion II USWVA
FAMIS Centra	FAMIS - Medallion II Central
FAMIS CMM Py	FAMIS - CMM Physician
FAMIS CMM Rx	FAMIS - CMM Pharmacy
FAMIS CMM Tr	FAMIS - CMM Transportation
FAMIS FFS	FAMIS - Fee-for-Service
FAMIS ICF	FAMIS - ICF
FAMIS LS Hos	FAMIS - Long Stay Hospital
FAMIS M3 MCO	FAMIS - Default Med-III MCO
FAMIS NorVA	FAMIS - Medallion II NorVA
FAMIS OS Prv	FAMIS - Out of State Provider
FAMIS PCP	FAMIS - Medallion PCP
FAMIS Plus	FAMIS Plus--Children Enrolled in Medicaid

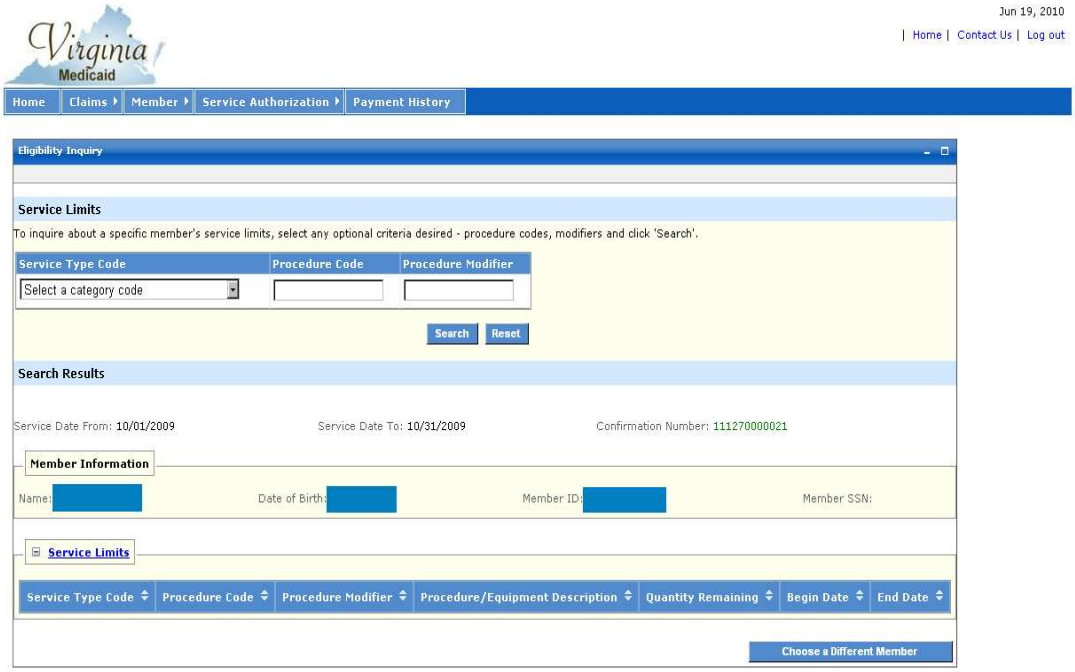
Abbreviated Description	Full Description
FAMIS Reg AL	FAMIS - Regular Assisted Living
FAMIS Select	FAMIS Select Premium Payments
FAMIS SNF	FAMIS - SNF
FAMIS Tidewr	FAMIS - Medallion II Tidewater
HIDP	Health Insurance Demonstration Pgm
HIPP Premium	HIPP Premium Payments
Hospice	Hospice
IFDDS Waiver	IFDSS Waiver
Med Co & Ded	Medicare Coinsurance & Deductibles
Med Premium	Medicare Premium
Medicaid FFS	Medicaid Fee-for-Service
Medicaid Wks	Medicaid Works
MFP	Money Follows Person
MR Waiver	MR Waiver
PACE	PACE
Pandemic	Pandemic Benefit Package
Plan First	Plan First - Family Planning Only
Premium Pay	Premium Payments
Prt Med Prem	Partial Medicare Premium
Reg Assist L	Regular Assisted Living
SLH	State and Local Hospital
TDO	Temporary Detention Order
VALTC Rich	VALTC Benefit Richmond
VALTC Tidw	VALTC Benefit Tidewater
Vent Waiver	Technology Assisted Waiver
XIX Central	Medicaid - Medallion II Central
XIX CMM Phys	Medicaid - CMM Physician
XIX CMM Rx	Medicaid - CMM Pharmacy
XIX CMM Tran	Medicaid - CMM Transportation

Abbreviated Description	Full Description
XIX Def. MCO	Medicaid - Default Mandatory MCO
XIX FFS Dial	Medicaid FFS Dialysis Services Only
XIX FFS Emer	Medicaid FFS Emergency Services Only
XIX Halifax	Medicaid - Medallion II Halifax
XIX ICF	Medicaid - ICF
XIX LS Hosp	Medicaid - Long stay Hospital
XIX M-3 CDPR	Medicaid - Medallion III MCO CDPR
XIX M-3 LSWV	Medicaid - Medallion III MCO LSWVA
XIX M-3 MCO	Medicaid - Default Med-III MCO
XIX M-3 NOVA	Medicaid - Medallion III MCO NorVA
XIX M-3 PCP	Medicaid - Medallion III PCP
XIX Northern	Medicaid - Medallion II Northern
XIX OS Prov	Medicaid - Out of State Provider
XIX PCP	Medicaid - Medallion PCP
XIX SNF	Medicaid - SNF
XIX Tidewtr	Medicaid - Medallion II Tidewater
XIX USWVA	Medicaid - Medallion II USWVA

The TPL Coverage Code in the TPL Spans section contains 271 Service Type Code that were determined from the MMIS TPL Coverage Code. The following table cross-references TPL Coverage Code with the Service Type Code.

TPL Coverage Code	Service Type Code
A – Medicare Part A	47 - Hospital
B – Medicare Part B	96 – Professional (Physician)
C - Cancer	87 - Cancer
D - Dental	35 – Dental Care
F – Home Health/ Personal Care	42 – Home Health Care
G – Mental Health	MH – Mental Health
H - Hospitalization	47 - Hospital
I – Indemnity/Accident	47 - Hospital
J – Dependent Pregnancy	69 – Maternity
K – Medicare Extended	30 – Health Benefit Plan Coverage
L – Managed Care (HMO/PPO)	30 – Health Benefit Plan Coverage
M – Major/Medical -Comprehensive	55 – Major Medical
N - Intermediate Care Nursing Facility	AH – Skilled Nursing Therapy - Room and Board
O – Optical/Vision	AL - Vision (Optometry)
P – Physician	96 – Professional (Physician)
Q – Chiropractor	33 - Chiropractive
R - Pharmacy	88 - Pharmacy
RD – Medicare Part D	88 - Pharmacy
S – Skilled Nursing	AH – Skilled Nursing Therapy - Room and Board
T - Transportation	56 – Medically Related Transportation
U – Uninsured Absent Parent	Non-Applicable
V – Rehabilitation/Physical Medicine	A9 - Rehabilitation
W – Worker's Compensation	30 – Health Benefit Plan Coverage
X – Preventive Care	68 – Well Baby Care

4.4 Member Service Limits Inquiry – Request Page



The Member Eligibility – Service Limit Inquiry will leverage the request criteria from the Member Eligibility Inquiry request, in conjunction with both required and optional search criteria.

Required Search Criteria

- Service Type Code
    - Service Type Code drop down options
        - Outpatient Psych
        - Home Health Skilled Nursing Visit
        - Home Health Aide
        - Occupational Therapy
        - Physical Therapy
        - Speech Therapy
        - Substance Abuse – FAMIS
        - Durable Medical Equipment – Purchase
        - Durable Medical Equipment - Rental

OR

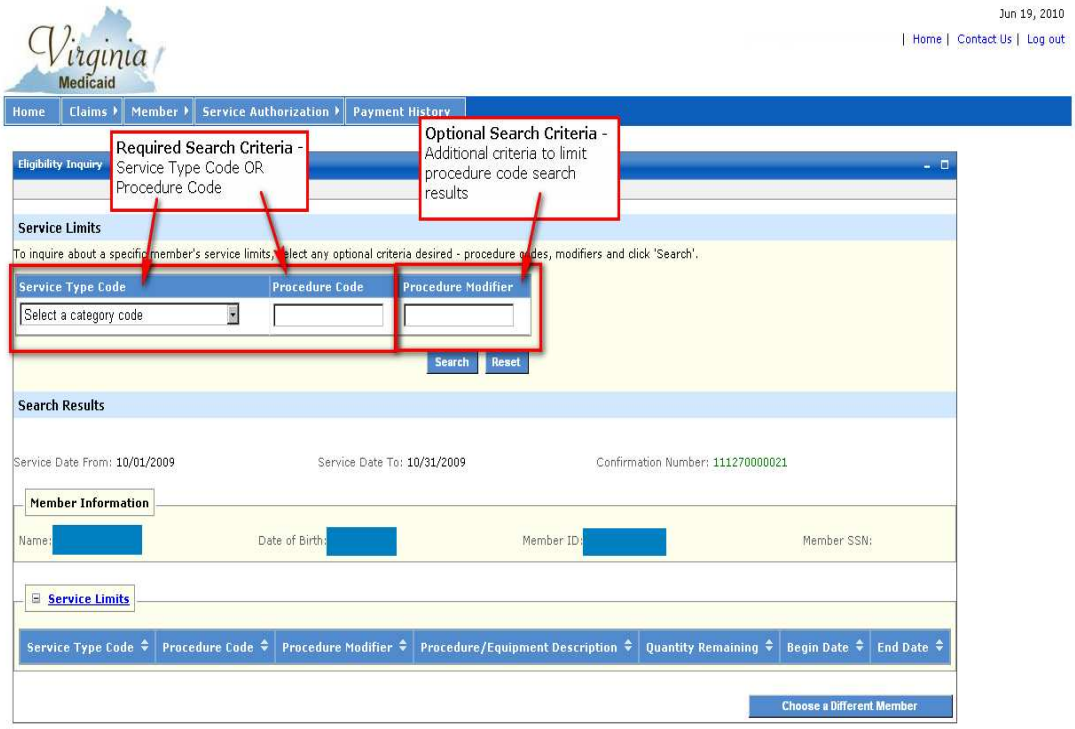
- Procedure Code

Optional Search Criteria – To be used in conjunction with the Procedure Code

- Procedure Modifier

The Service Type Code option can only be used by providers that fall into one of the following categories:

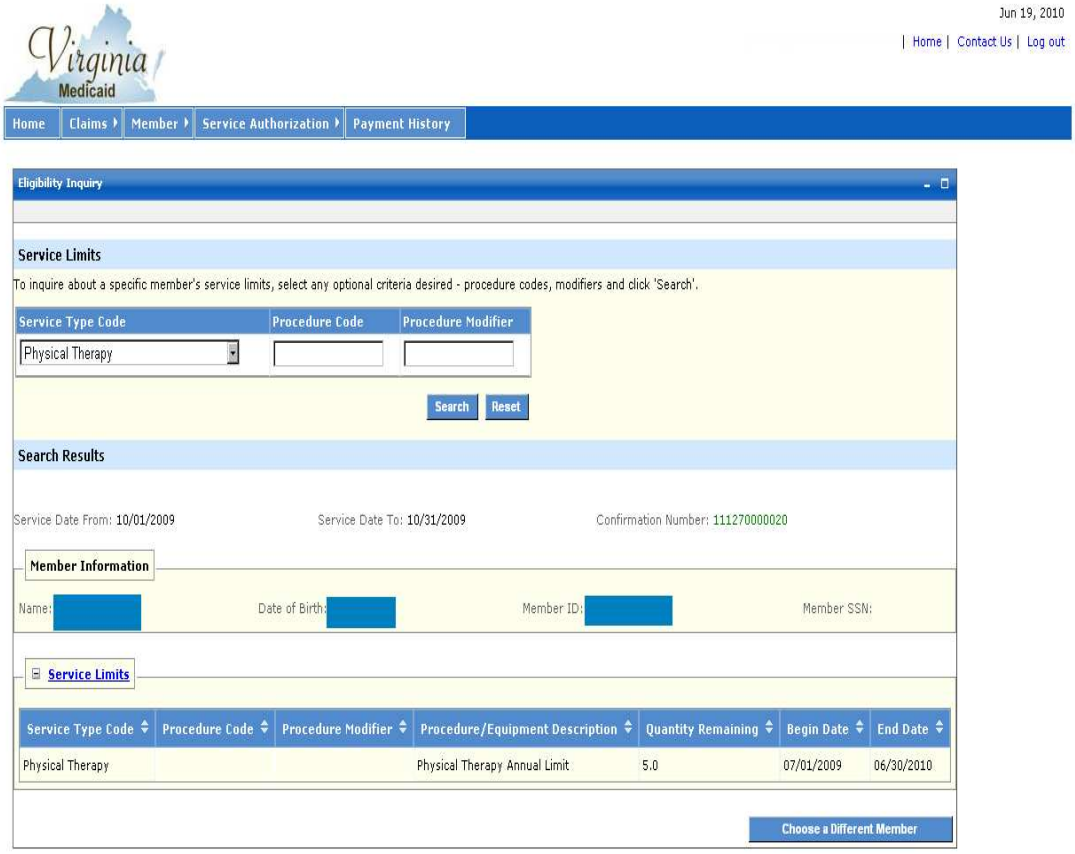
- 12 – Durable Medical Equipment Purchase
- 18 – Durable Medical Equipment Rental
- 42 – Home Health Care (Home Health Aide)
- 44 – Home Health Visits (Skilled Nursing)
- A8 – Psychiatric Outpatient
- AD – Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy
- AI – Substance Abuse



After entering any desired selection criteria, you will click 'Search' to obtain any records resulting from the search criteria.

4.5 Member Service Limits Inquiry – Response Page

The Member Eligibility – Service Limits Inquiry results reflect member service limits information.



The Member Eligibility – Service Limits detail is divided in to the following sections:

Eligibility Information (carried from the Member Eligibility Response page)
- Service Date From
- Service Date To
- Confirmation Number

Member Information (carried from the Member Eligibility Response page)
- Name
- Date of Birth
- Member ID
- Member SSN (only displayed if entered as part of the search criteria)

Service Limits

- Service Type Code
- Procedure Code
- Procedure Modifier
- Procedure/Equipment Description
- Quantity Remaining (Quantity Approved)
- Begin Date
- End Date

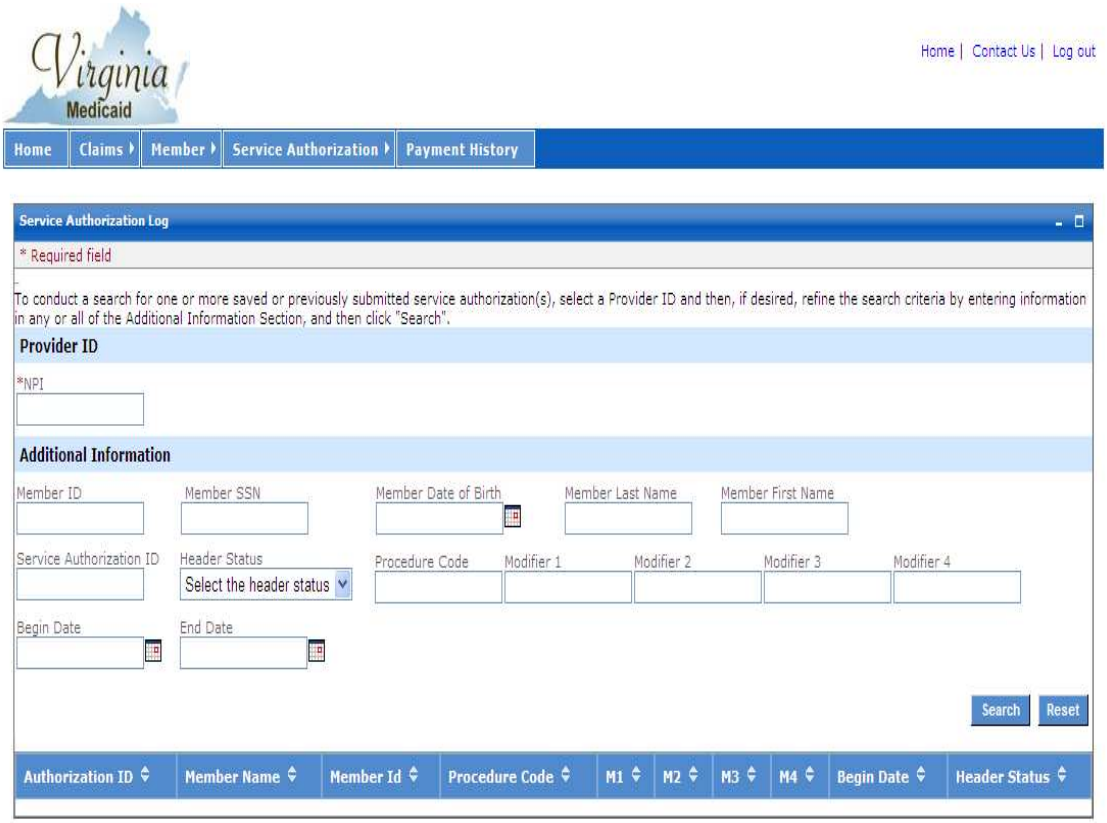
From this portal page, you can select another member by clicking on 'Choose a Different Member'.

5.0 Service Authorization Inquiry

Select the Service Authorization Log Inquiry from the Service Authorization drop down menu.

You will be directed to the Service Authorization Log Inquiry Request portal page for selection criteria entry.

5.1 Service Authorization Log Inquiry – Request Page



The Service Authorization Log Inquiry has both required and optional search criteria.

Required Search Criteria

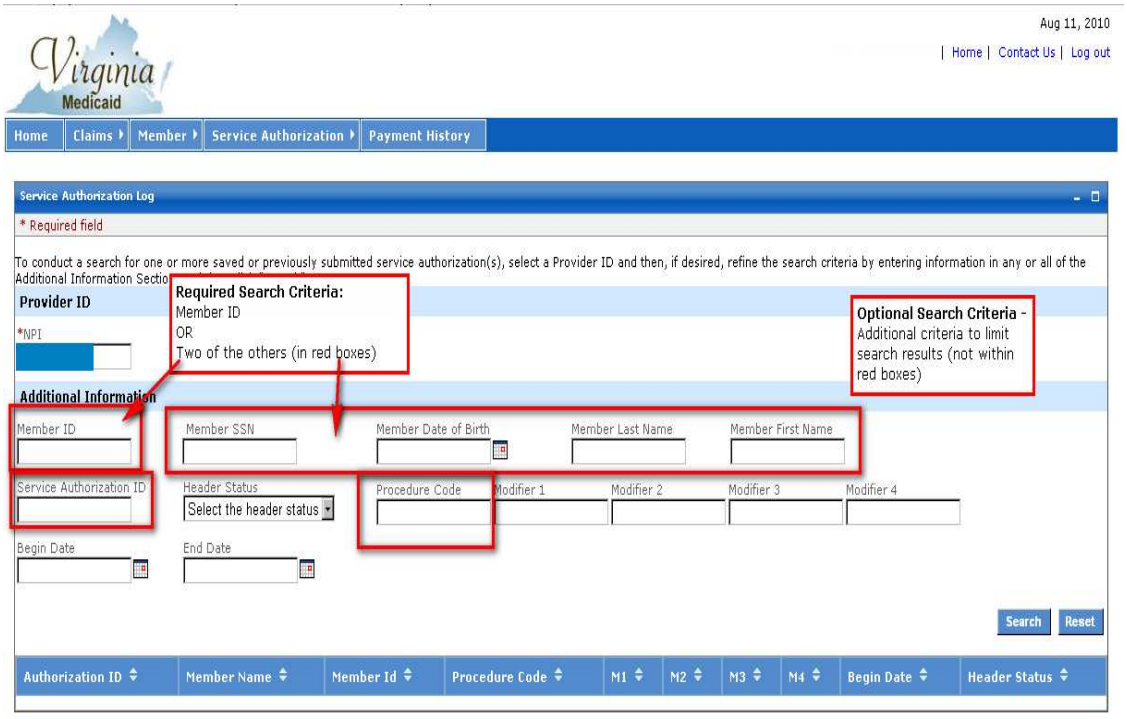
- Member ID

OR 2 of the following:

- Member SSN
- Member Date of Birth
- Member Last Name/First Name
- Service Authorization ID – Identification number associated to the Service Authorization OR
- Procedure Code

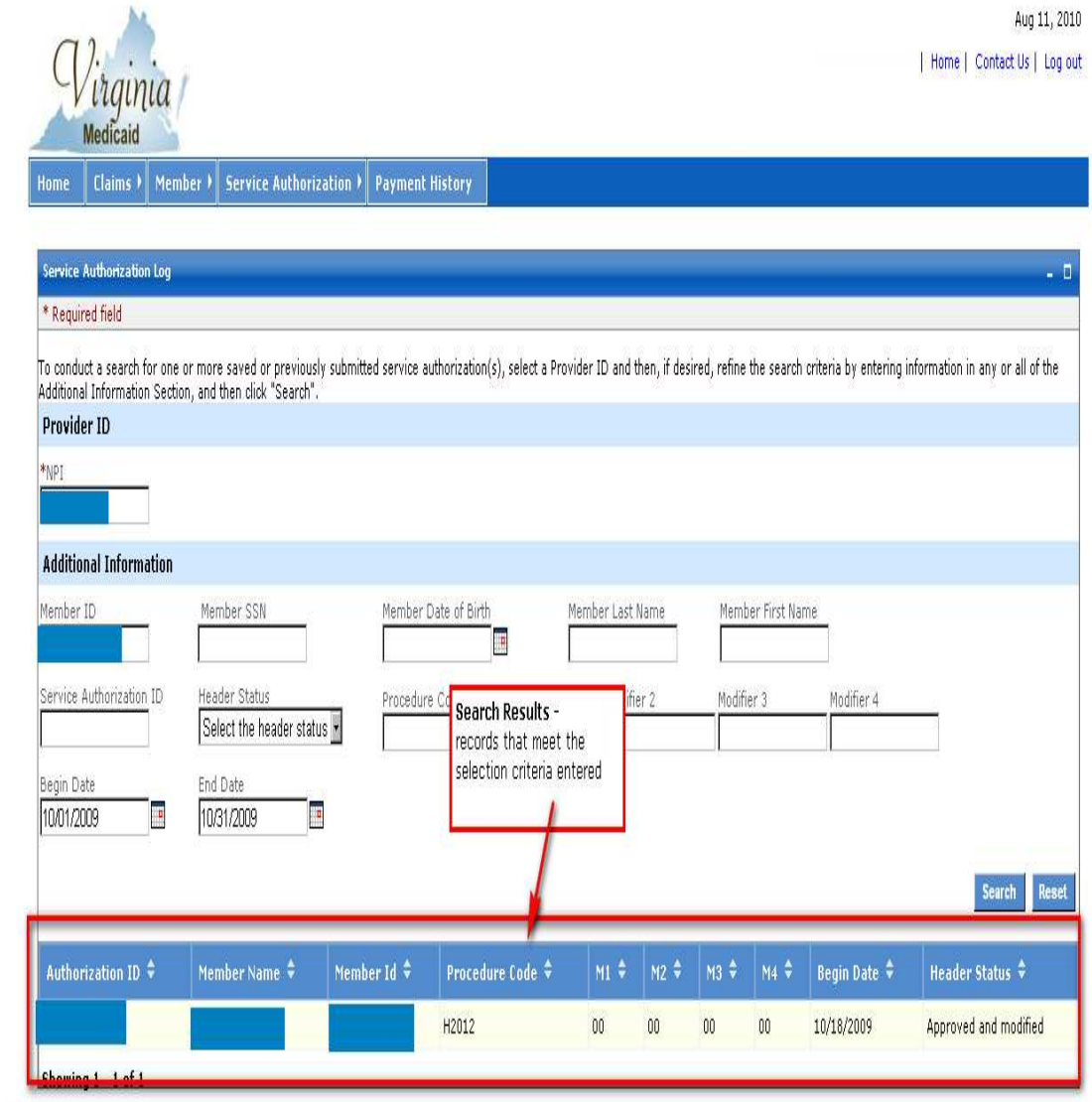
Optional Search Criteria – To be used in conjunction with the required data

- Service Authorization Dates – The begin and end service authorization dates
    - Date format – MM/DD/CCYY
    - If no service dates are entered, the default will be the current date
    - Service Authorization dates can not span more than one (1) year
    - If Service Authorization date range is just one day, that date will need to be entered in both the begin and end date fields
- Header Status – Current status of the Service Authorization Log
    - Header Status drop down options:
        - Approved
        - Denied
        - Pended
        - Rejected
        - Received
- Modifiers 1 – 4 - To be used in conjunction with the procedure code



After entering any desired selection criteria, you will click 'Search' to obtain any records resulting from the search criteria.

5.2 Service Authorization Log Inquiry – Search Results

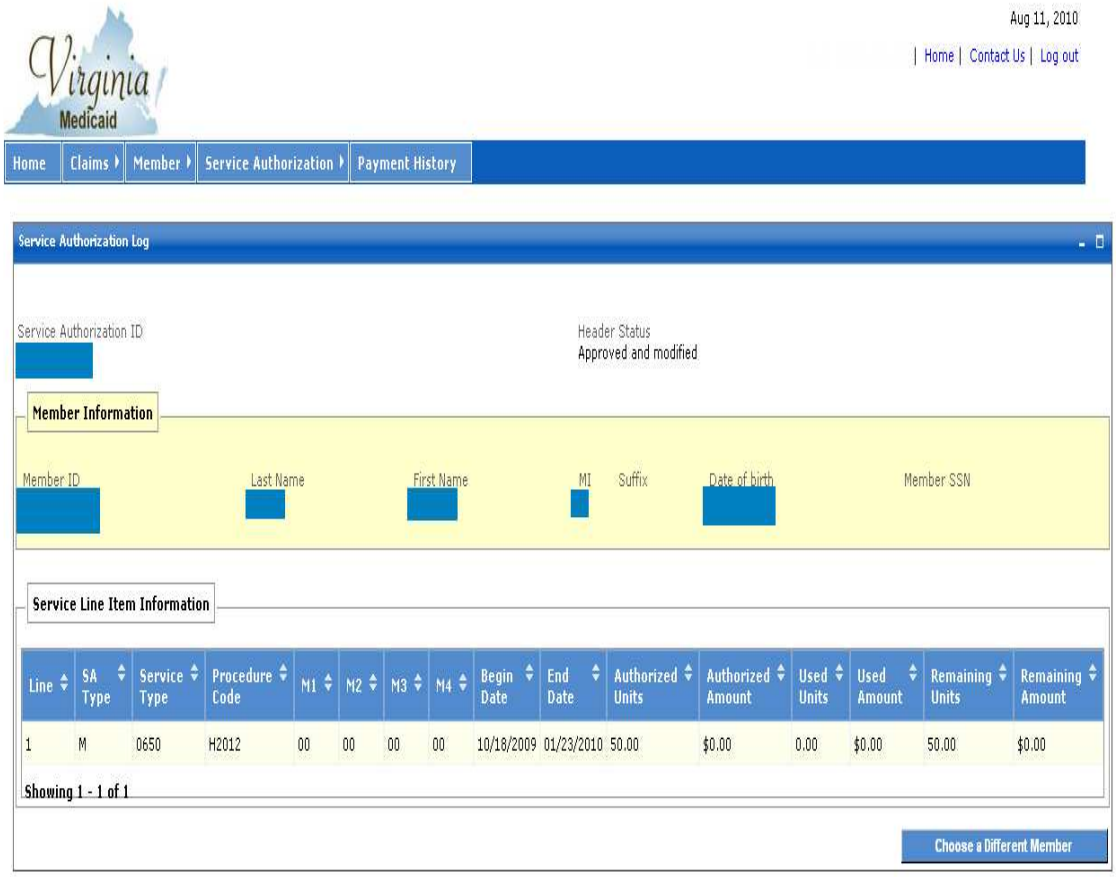


Results that match the search criteria entered will be displayed in the 'Search Results' section.

Clicking on the individual search result record will direct you to the Response page containing detailed information for that record.

5.3 Service Authorization Log Inquiry – Response Page

The Service Authorization Log Inquiry results reflect the service authorization detail.



The Service Authorization Detail is divided in to the following sections:

- Service Authorization ID

Member Data
- Member ID
- Last Name
- First Name
- Middle Initial
- Suffix
- Date of Birth
- Member SSN (will only be displayed if used in the selection criteria)

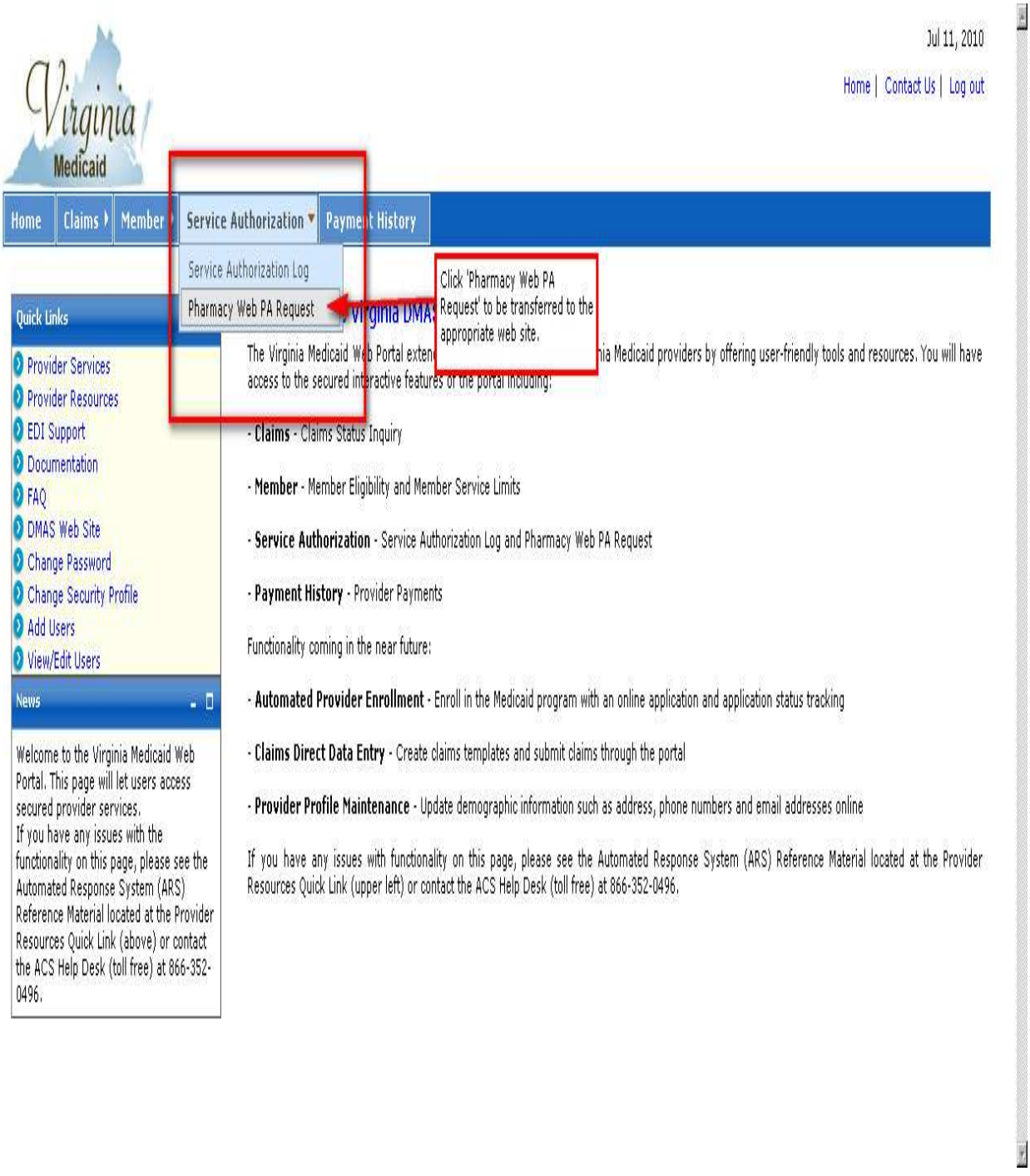
Service Line Item Information

- Line Number
- Service Authorization Type
- Service Type Code
- Procedure Code
- Modifiers 1 – 4
- Begin Date
- End Date
- Authorized Units
- Authorized Amount
- Used Units
- Used Amount
- Remaining Units
- Remaining Amount

From this portal page, you can select another member by clicking on 'Choose a Different Member'.

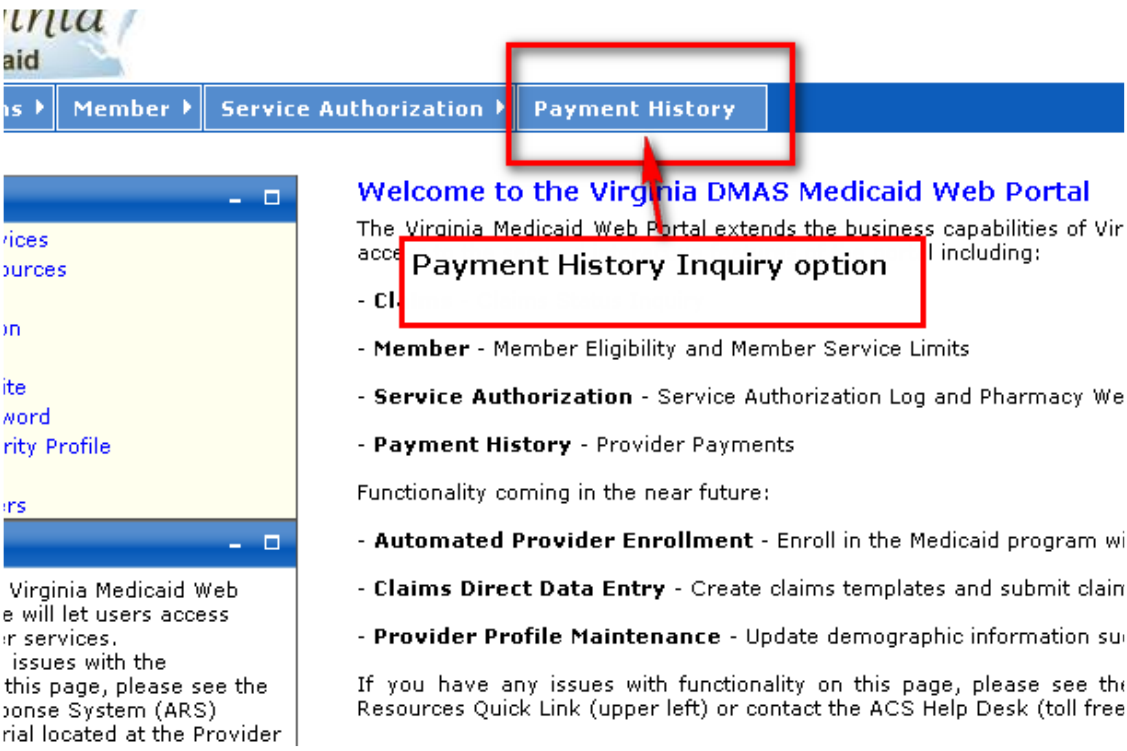
5.4 Pharmacy Web PA Link

From the Service Authorization tab, the link for 'Pharmacy Web PA' can be accessed.



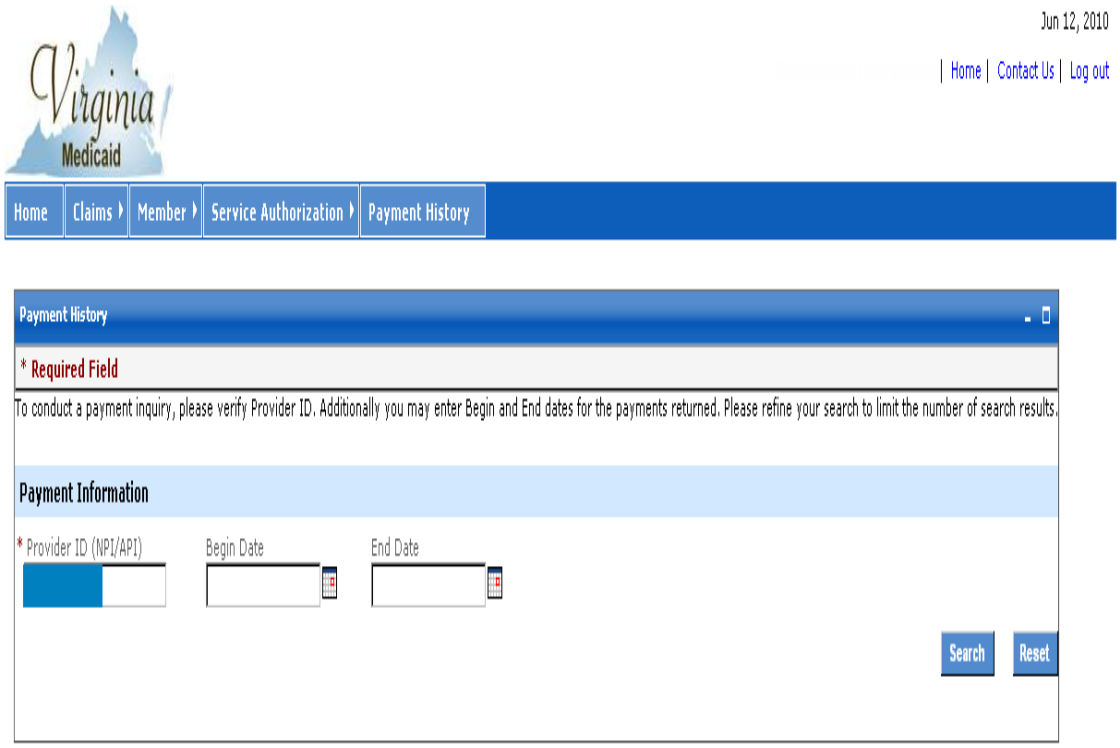
6.0 Payment History Inquiry

Select the Payment History Inquiry from the portal title bar.



You will be directed to the Payment History Inquiry Request portal page for selection criteria entry.

6.1 Payment History Inquiry – Request Page



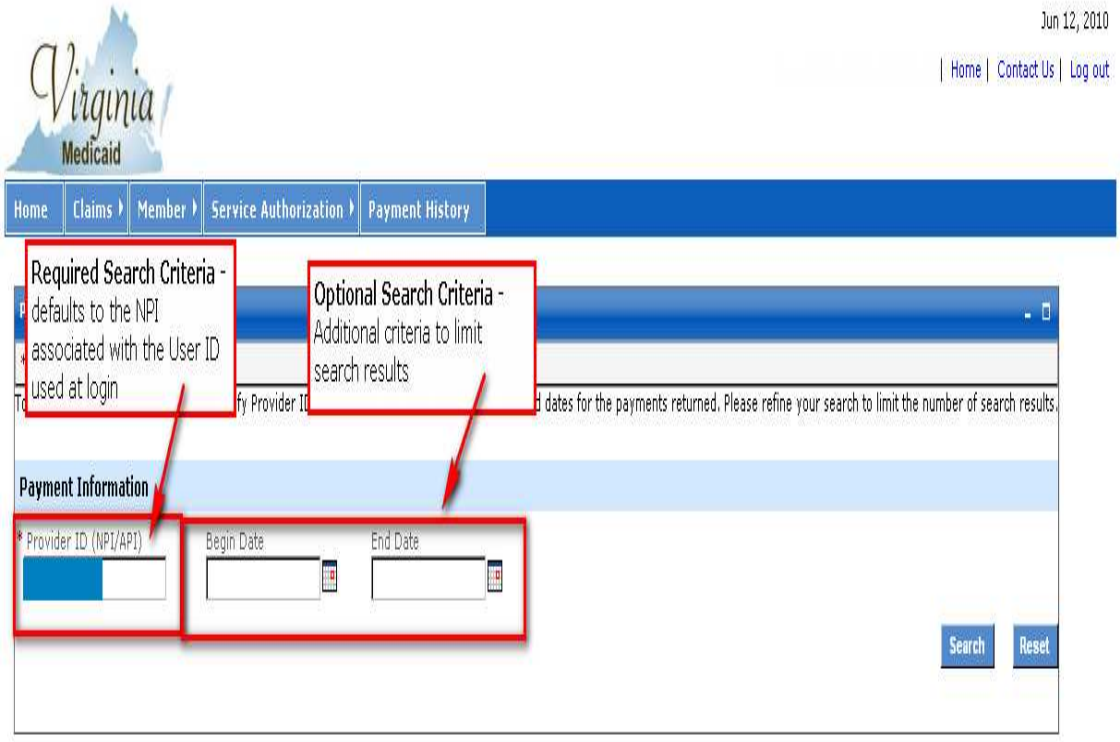
The Payment History Inquiry has both required and optional search criteria.

Required Search Criteria

- Billing Provider ID – This field defaults to the NPI associated with the User ID used at the time of login.

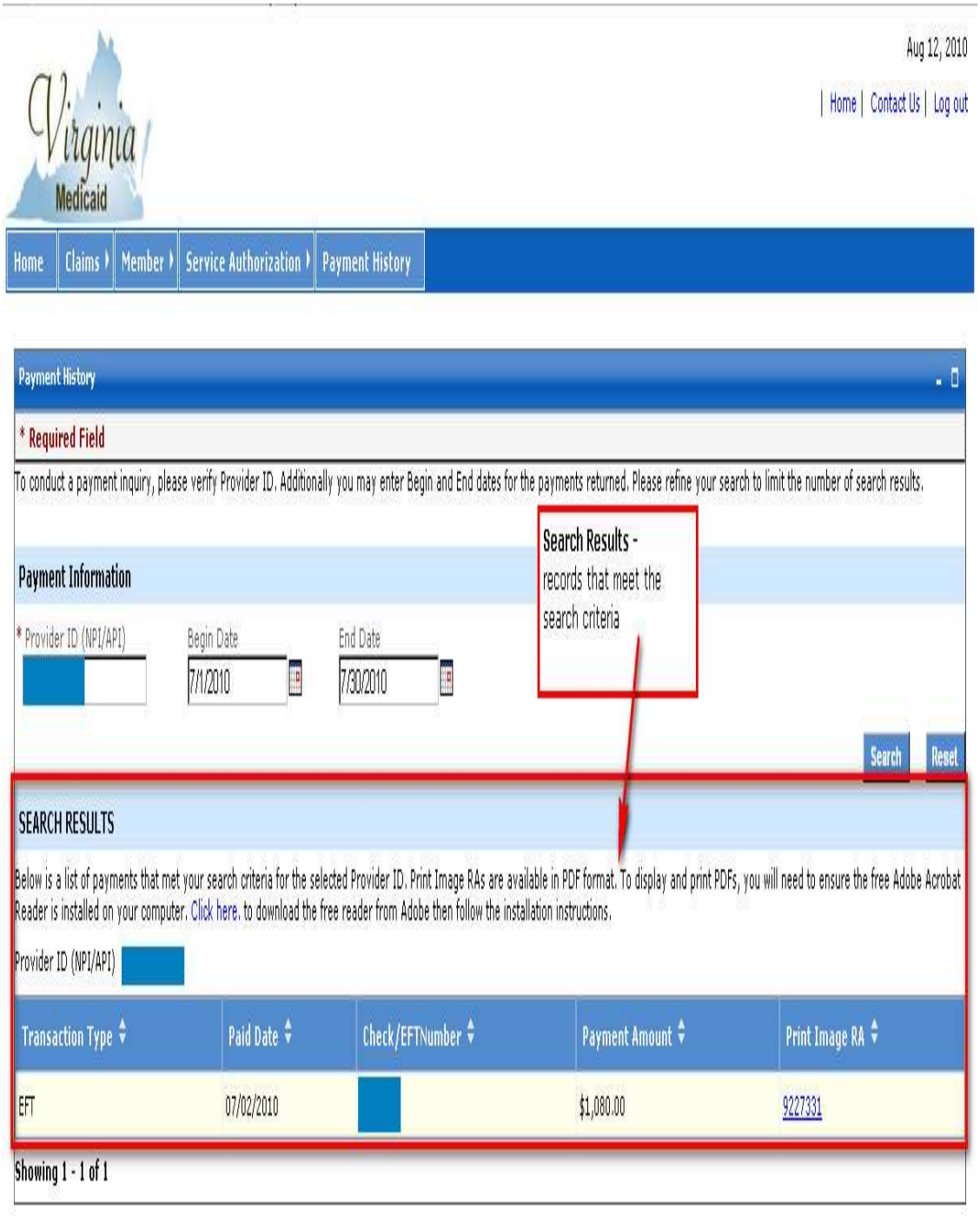
Optional Search Criteria – To be used in conjunction with the Billing Provider ID

- Payment Dates – The begin and end payment dates
    - Date format – MM/DD/CCYY



After entering any desired selection criteria, you will click 'Search' to obtain any records resulting from the search criteria.

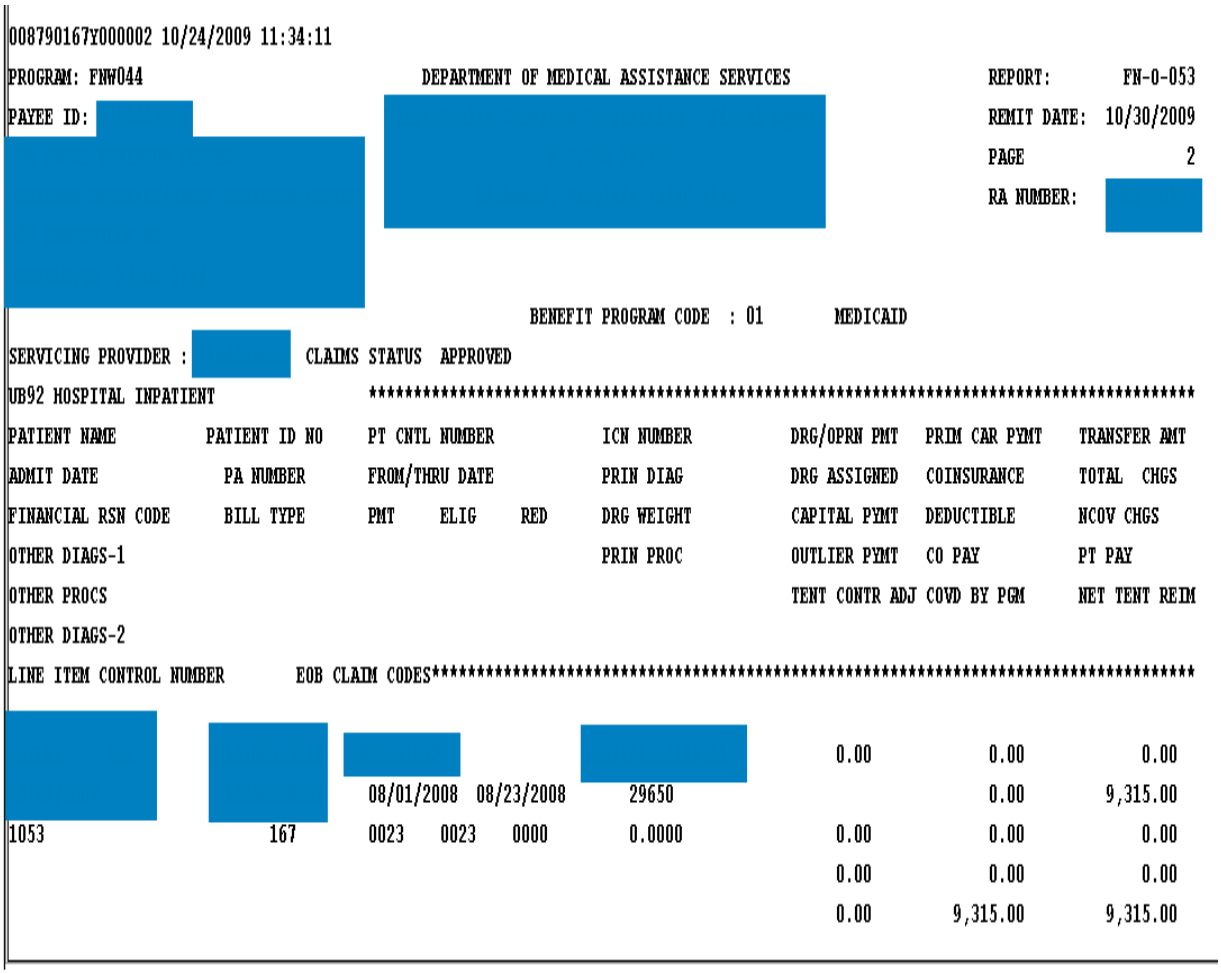
6.2 Payment History Inquiry – Search Results



Results that match the search criteria entered will be displayed in the 'Search Results' section.

Clicking on the 'Print Image RA' of the desired payment amount will display the image of the remittance advice.

Print Image of selected Remittance Advice



008790167Y000002 10/24/2009 11:34:11

PROGRAM: FNW044 DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT: FN-0-053

PAYEE ID: [redacted] REMIT DATE: 10/30/2009

PAGE 2

RA NUMBER: [redacted]

BENEFIT PROGRAM CODE : 01 MEDICAID

SERVICING PROVIDER : [redacted] CLAIMS STATUS APPROVED

UB92 HOSPITAL INPATIENT **********

PATIENT NAME	PATIENT ID NO	PT CNTL NUMBER	ICN NUMBER	DRG/OPRN PMT	PRIM CAR PYMT	TRANSFER AMT
ADMIT DATE	PA NUMBER	FROM/THRU DATE	PRIN DIAG	DRG ASSIGNED	COINSURANCE	TOTAL CHGS
FINANCIAL RSN CODE	BILL TYPE	PMT ELIG RED	DRG WEIGHT	CAPITAL PYMT	DEDUCTIBLE	NCOV CHGS
OTHER DIAGS-1			PRIN PROC	OUTLIER PYMT	CO PAY	PT PAY
OTHER PROCS				TENT CONTR ADJ	COVD BY PGM	NET TENT REIM
OTHER DIAGS-2						

LINE ITEM CONTROL NUMBER EOB CLAIM CODES**********

[redacted]	[redacted]	[redacted]	[redacted]	0.00	0.00	0.00
		08/01/2008 08/23/2008	29650		0.00	9,315.00
1053	167	0023 0023 0000	0.0000	0.00	0.00	0.00
				0.00	0.00	0.00
				0.00	9,315.00	9,315.00

Appendix A – Glossary of Terms

Term	Definition
API	Atypical Provider Identifier – assigned by the Commonwealth of Virginia for providers that are not eligible for an NPI (i.e. transportation providers)
Authorized User	The staff that is responsible for performing provider support functions
Automated Response System (ARS)	The Web Portal system that gives provider organizations access to provider support functionality such as Member Eligibility Inquiries, Service Limit Inquiries, Claims Status Inquiries, etc.
DME	Durable Medical Equipment
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
ICN	Internal Control Number (used on claims)
ID	Identification Number
Navigational Tabs	Tabs on a portal page that will take the user to other sections in the portal or bring up documents.
NPI	National Provider Identifier
Organization Administrator (OrgAdmin)	The person who can also establish the Authorized User role and can reset the passwords, activate and deactivate users and lock and unlock user IDs for Authorized Users.
Portlets	Sections or 'boxes' that comprise a web portal page
Primary Account Holder	The person who will perform the initial web registration and will establish the security needed to allow the access to secured provider functionality
Provider Organization	Either an individual provider or group provider and the user community in support of them
RA	Remittance Advice
SSN	Social Security Number
TPL	Third Party Liability
User	Any person that will access the Web Portal and leverage the functionality within it

Appendix B – ARS FAQ

Virginia Medicaid Web Portal
Automated Response System (ARS)
Frequently Asked Questions
Revised 08/12/2010

General Questions

How do I access the new Virginia Medicaid Web Portal?

The new Virginia Medicaid Web Portal can be accessed through the following link: www.virginiamedicaid.dmas.virginia.gov

Is the functionality replicated in the new portal?

There are some selection criteria that are different in the new portal than it was in the previous portal. The selection criteria are being modified and will be released in September 2010. The differences between the current selection criteria and the criteria of the previous portal is detailed within the FAQ for each section where a difference exists.

Is the system HIPAA compliant?

Yes, HIPAA-covered portions of the system, 270/271 Eligibility and 276/277 Claims Status are HIPAA compliant. The HIPAA standards have an exception called Direct Data Entry (DDE). HIPAA-covered portions of the system do "use applicable data content and data conditions of the standard".

Member Eligibility & Service Limits Inquiry

Member Eligibility Inquiry

What are the required and optional selection criteria?

The Member Eligibility Inquiry has both required and optional search criteria.

Required Search Criteria – To be used in conjunction with the Member ID or Member information

- Service Dates – The begin and end service dates
    - Date format – MM/DD/CCYY
    - Service date range can not span more than one (1) calendar month (i.e. 06/01/2010 – 06/30/2010)
    - If the service date range is just one day, it will need to be entered in both the begin and end date fields
    - Service From Date must be within one year from the current date
    - Future dates are not allowed with the exception of the following:
        - From the 1st – 20th of the month, results can not go past the end of the current month (i.e. if current date is June 12th, results can not go past the end of June)
        - From the 21st through the end of the month, results can not go past the end of the next month (i.e. if current date is June 24th, results can not go past the end of July)

Optional Search Criteria

- Member ID – The Medicaid ID number associated with the Member

OR one of the following combinations:

- Member SSN and Member Date of Birth
- Member SSN and Member Name (First & Last Name)
- Member Date of Birth and Member Name (First & Last Name)

What differences are there in the selection criteria between the new and previous portals?

There are no differences in selection criteria between the new and previous portals.

Can I inquire on more than one member initially?

From the Member Eligibility Request page, you can enter from one to ten members at a time.

How do I inquire on another member?

From the Member Eligibility Response page, you can select another member by clicking on 'Choose a Different Member'.

What is the meaning of the Special Indicator Codes?

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services.

- A - Member is under 21 and has no copay
- B – Member is receiving long term care or other community based services and no copay is required for any service
- C – All other members and copays applying for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation services.

  The following copay exemptions apply:
  - Members in managed care organizations may not have to pay copays (FAMIS members enrolled in a MCO do have copays);
  - No copays for pregnancy-related services or family planning clinic visits, drugs, and supplies;
  - No copays for Durable Medical Equipment and supplies

Benefit Plan Definitions

The Plan Description in the Benefit Plan section contains abbreviated descriptions. The following table cross-references a short description with a full description.

Abbreviated Description	Full Description
Aged Waiver	Elderly and Disabled Waiver
AIDS Waiver	AIDS Waiver
Alzheimer Al	Alzheimer's Assisted Living
ASM ACR ASSM	ACR Assessments
ASM NH LVL 1	Assessments Nursing Home Level 1
ASM NH LVL 2	Assessments Nursing Home Level 2
CMH Waiver	CMH Waiver
DS Waiver	Day Support Waiver
EI	Early Intervention
FAMIS - CDPR	FAMIS - Medallion II CDPR
FAMIS - Halr	FAMIS - Medallion II Halifax
FAMIS - LSWV	FAMIS - Medallion II LSWVA
FAMIS - MCO	FAMIS - Default Mandatory MCO
FAMIS - USWV	FAMIS - Medallion II USWVA
FAMIS Centra	FAMIS - Medallion II Central
FAMIS CMM Py	FAMIS - CMM Physician
FAMIS CMM Rx	FAMIS - CMM Pharmacy
FAMIS CMM Tr	FAMIS - CMM Transportation
FAMIS FFS	FAMIS - Fee-for-Service
FAMIS ICF	FAMIS - ICF
FAMIS LS Hos	FAMIS - Long Stay Hospital
FAMIS M3 MCO	FAMIS - Default Med-III MCO
FAMIS NorVA	FAMIS - Medallion II NorVA
FAMIS OS Prv	FAMIS - Out of State Provider
FAMIS PCP	FAMIS - Medallion PCP
FAMIS Plus	FAMIS Plus--Children Enrolled in Medicaid
FAMIS Reg AL	FAMIS - Regular Assisted Living
FAMIS Select	FAMIS Select Premium Payments

Abbreviated Description	Full Description
FAMIS SNF	FAMIS - SNF
FAMIS Tidewr	FAMIS - Medallion II Tidewater
HIDP	Health Insurance Demonstration Pgm
HIPP Premium	HIPP Premium Payments
Hospice	Hospice
IFDDS Waiver	IFDSS Waiver
Med Co & Ded	Medicare Coinsurance & Deductibles
Med Premium	Medicare Premium
Medicaid FFS	Medicaid Fee-for-Service
Medicaid Wks	Medicaid Works
MFP	Money Follows Person
MR Waiver	MR Waiver
PACE	PACE
Pandemic	Pandemic Benefit Package
Plan First	Plan First - Family Planning Only
Premium Pay	Premium Payments
Prt Med Prem	Partial Medicare Premium
Reg Assist L	Regular Assisted Living
SLH	State and Local Hospital
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VALTC Rich	VALTC Benefit Richmond
VALTC Tidw	VALTC Benefit Tidewater
Vent Waiver	Technology Assisted Waiver
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XIX CMM Phys	Medicaid - CMM Physician
XIX CMM Rx	Medicaid - CMM Pharmacy
XIX CMM Tran	Medicaid - CMM Transportation
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XIX FFS Dial	Medicaid FFS Dialysis Services Only
XIX FFS Emer	Medicaid FFS Emergency Services Only
XIX Halifax	Medicaid - Medallion II Halifax
XIX ICF	Medicaid - ICF

Abbreviated Description	Full Description
XIX LS Hosp	Medicaid - Long stay Hospital
XIX M-3 CDPR	Medicaid - Medallion III MCO CDPR
XIX M-3 LSWV	Medicaid - Medallion III MCO LSWVA
XIX M-3 MCO	Medicaid - Default Med-III MCO
XIX M-3 NOVA	Medicaid - Medallion III MCO NorVA
XIX M-3 PCP	Medicaid - Medallion III PCP
XIX Northern	Medicaid - Medallion II Northern
XIX OS Prov	Medicaid - Out of State Provider
XIX PCP	Medicaid - Medallion PCP
XIX SNF	Medicaid - SNF
XIX Tidewtr	Medicaid - Medallion II Tidewater
XIX USWVA	Medicaid - Medallion II USWVA

Service Limits Inquiry

How do I inquire on a member's service limits?

From the Member Eligibility Response page, you can select to inquire on the member's service limits by clicking on 'Service Limits'.

What are the required and optional selection criteria?

The Member Eligibility – Service Limit Inquiry will leverage the request criteria from the Member Eligibility Inquiry request, in conjunction with both required and optional search criteria.

Required Search Criteria

- Service Type Code
    - Service Type Code drop down options
        - Outpatient Psych
        - Home Health Skilled Nursing Visit
        - Home Health Aide
        - Occupational Therapy
        - Physical Therapy
        - Speech Therapy
        - Substance Abuse – FAMIS
        - Durable Medical Equipment – Purchase
        - Durable Medical Equipment - Rental

OR

- Procedure Code

Optional Search Criteria – To be used in conjunction with the Procedure Code

- Procedure Modifier

Can the Service Type Code option be used by any provider type?

The Service Type Code option can only be used by providers that fall into one of the following categories:

- 12 – Durable Medical Equipment Purchase
- 18 – Durable Medical Equipment Rental
- 42 – Home Health Care (Home Health Aide)
- 44 – Home Health Visits (Skilled Nursing)
- A8 – Psychiatric Outpatient
- AD – Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy
- AI – Substance Abuse

How do I inquire on another member?

From the Service Limit Response page, you can select another member by clicking on 'Choose a Different Member'.

Claims Status Inquiry

What are the required and optional selection criteria?

The Claims Status Inquiry has both required and optional search criteria.

Required Search Criteria

- Billing Provider ID – This field defaults to the NPI associated with the User ID used at the time of login

Optional Search Criteria – To be used in conjunction with the Billing Provider ID

- Servicing Provider ID – The NPI associated with a provider who performed services for the Billing Provider noted

AND/OR

- ICN – The Internal Control Number associated with a particular claim

OR

- Claims Service Dates – The service begin and end dates
    - Date format – MM/DD/CCYY
    - If no service dates are entered, the default will be the current date
    - Service date range can not span more than one (1) month
    - If the service date range is just one day, the date will need to be entered in both the begin and end date fields
    - The service date(s) must be within the last 24 months.
- Claims Status – Status of the claims to be returned in the results selection
    - The claims status will be used in conjunction with the service date range (including the current date default)
    - Claims Status drop down options:
        - Paid
        - Denied
        - Pended
        - To Be Paid
        - To Be Denied

AND/OR

- Member ID – The Medicaid ID number associated with the Member
    - This criteria can be used independently or in conjunction with the service date range and/or the claims status

How does this compare with the HIPAA 835?

As a result of a claim, the 835 comes automatically in a batch of transactions. The 835 contains more information on claim status. This is not relevant to the inquiry on the web.

Service Authorization Log Inquiry

What are the required and optional selection criteria?

The Service Authorization Log Inquiry has both required and optional search criteria.

Required Search Criteria

- Member ID

OR 2 of the following:

- Member SSN
- Member Date of Birth
- Member Last Name/First Name
- Service Authorization ID – Identification number associated to the Service Authorization OR
- Procedure Code

Optional Search Criteria – To be used in conjunction with the required data

- Service Authorization Dates – The begin and end service authorization dates
    - Date format – MM/DD/CCYY
    - If no service dates are entered, the default will be the current date
    - Service Authorization dates can not span more than one (1) year
    - If Service Authorization date range is just one day, that date will need to be entered in both the begin and end date fields
- Header Status – Current status of the Service Authorization Log
    - Header Status drop down options:
        - Approved
        - Denied
        - Pended
        - Rejected
        - Received
- Modifiers 1 – 4 - To be used in conjunction with the procedure code

Can I authorize a procedure for a member?

No, the Service Authorization Log is a historical list of service authorizations. The Service Authorization Log shows the results of previous, successful authorizations.

Payment History Inquiry

What are the required and optional selection criteria?

The Payment History Inquiry has both required and optional search criteria.

Required Search Criteria

- Billing Provider ID – This field defaults to the NPI associated with the User ID used at the time of login.

Optional Search Criteria – To be used in conjunction with the Billing Provider ID

- Payment Dates – The begin and end payment dates
    - Date format – MM/DD/CCYY

What differences are there in the selection criteria between the new and previous portals?

There are no differences in selection criteria between the new and previous portals.

On the Payment History Response page, what is the 'Print Image RA'?

Clicking on the 'Print Image RA' of the desired payment amount will display the image of the remittance advice.